PASTORAL CARE TO AFRICAN-AMERICAN MALE VICTIMS OF VIOLENCE AND THEIR FAMILIES IN A HOSPITAL SETTING

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ABSTRACT

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This final document addresses the spiritual needs of African-American males who are victims of violent injuries at the Medical College of Virginia Hospitals. Through direct crises and supportive pastoral care with patients and their families, the grace of God was experienced in the midst of the trauma. Ministry reports are narratives that told the story of victims who were dealing with the horrifying results of violence that is found in our society. Interventions by chaplains offering spiritual care helped victims debrief about their trauma and become empowered by recognizing the presence of God, which transformed them.

ACKNOWLEDGMENTS

I wish to thank those who have faithfully contributed their time, energy, and skills to help complete this dissertation. Learning has been collaborative with my peers in the Communities in Crisis Holistic Ministry group under the direction of Dr. Leah Gaskins Fitchue, a woman whose excellent example of leadership in theological education inspired me. Dr. George McCrae, who shared from the living pastoral document through his ministry and leadership at Mt. Tabor Baptist Church in Miami, Florida was inspirational.

The leadership of Dr. J. T. Roberson, Dean of the Doctoral Studies Program at United Theological Seminary, was evident in informative intensive sessions that nurtured my ministry. His advice and encouragement are appreciated. The insightful questions and consultation by Dr. Glenn Routt was a tremendous blessing. The constant encouragement and support from Dr. Jimmy McCrary, Jr., a consultant and partner in ministry, demonstrated how pastoral care and evangelism complement each other. The context associates and the Reverend Rosalind Bradley helped me to understand aspects of the Medical College of Virginia Hospital/Virginia Commonwealth University community and interpret the meaning of events.

To patients, survivors, and family members who shared their stories, thank you. Your narratives are the body of this work. Clinical Pastoral Education students helped me to learn about the journeys of patients from their ministry reports and to deepen our relationship. Dr. Lex Tartaglia, chairman of Patient Counseling faculty and the staff of the Pastoral Care Department and to the members of Beulah A.M.E. Church, I thank you for your support.

My daughters, Tina and Deia, listened to my ideas and always affirmed their love and respect for my ministry. My son, Randolph, helped me to recognize that I can never see a black man suffer and not realize that he could be my son. Special thanks to Michelle Morris, Cathy Overton, and Dallas Gayle for typing this document and to Ann Hogan and Rosalind Bradley for editing it. Your gifts of your time, energy, talent, and skills affirm the grace of God.

DEDICATION

In loving memory of my husband, Reverend Volover W. Williams

INTRODUCTION

This dissertation reflects the suffering of many African-American men from hopelessness and despair. They live in communities that refuse to address their needs, which could help them lead more productive lives.

This dissertation reflects suffering of many African-American males who experience violent injuries in their own communities. The wounds that bring them into the hospital are symbolic of the danger, lawlessness, and evil found in the streets of Richmond. It is true that some victims simply were in the wrong place at the wrong time. I call them casual victims. Violence is a result of a very complex social system that neglects African-American communities, especially the men and boys.

Chapter One introduces the context for this model of ministry with a history and overview of the Medical College of Virginia/Virginia Commonwealth University. A public hospital that provides indigent care, its mission is medical education, research and care with dignity.

Chapter Two provides a review of traditional pastoral care literature, which gave an understanding of the basic theory that informs ministry. The works of Wimberly, Cooper-Lewter, and Henry Mitchell in *Soul Theology*, and *Personality, Providence and Power*, provided by Walter Brueggemann and others created an exciting new paradigm.

Chapter Three addresses the causes of violence, the social impact to communities in crisis, the identity of the chaplain practicing in a crisis context, and biblical theories about violence and healing and transformation for survivors.

Chapter Four contains fifteen ministry report cases from patients with intentional injuries at MCVH/VCU. Narrative theology and pastoral/patient debriefing record their experiences.

Chapter Five has interviews focusing on the perspective of violence in African-American communities. Interviewed are Dr. Napoleon Peoples, a psychologist; the Reverend Kenneth Dennis, a pastor and police chaplain; a trauma nurse; and two survivors of violence.

Chapter Six is the spiritual autobiography of Reverend Cecelia Williams.

Chapter Seven contains the results of the model.

Concluding sections are the appendices and the bibliography.

CHAPTER ONE

CONTEXT

Medical College of Virginia Hospitals/Virginia Commonwealth University, Richmond, Virginia

Virginia Commonwealth University's Medical College of Virginia Hospitals (MCVH) is a 750-bed general hospital located in downtown Richmond, Virginia. Its mission is care of patients, education, and research through the use of state-of-the art medical technology. The emergency room serves the immediate community and is the regional trauma center. Organ transplantation, burn injuries, and other acute medical crises and traumas are among the specialties focused upon at MCVH. Medical care is offered to all persons without limitation due to ability to pay. Because MCVH is designated as the major provider of care to indigent patients, a large percentage of the patients' economic levels fall below the national poverty level. Patients come to MCVH because of its excellent diagnostic and treatment capabilities. Faculty physicians admit their private patients and many patients are referred from other medical facilities due to the complexity of their medical conditions. In addition, the Virginia correctional

facilities send inmates to MCVH for their health care needs. At this time, the acuity rate with inpatients is higher than ever before. While the census has decreased, the demands for care have tremendously increased.

MCVH is surrounded by the downtown area. The City of Richmond is a diverse community. Racially, it is 65 percent African-American and 35 percent Caucasian and others. Although the community diversity is represented in the hospitals' patient population, the racial makeup within the hospitals is approximately 55 percent Caucasian and 45 percent African-American and others. This factor can be attributed to the fact that MCVH is used state-wide. Many patients come to this facility who live more than one hundred miles away.

History of the Medical College of Virginia Hospitals

The Medical College of Virginia Hospitals actually predates the Virginia Commonwealth University, which is located in the heart of Richmond. The University takes its founding date from the Medical College of Virginia, as detailed in Virginius Dabney's *Virginia Commonwealth University: Sequential Centennial History*, (Charlottesville, Virginia University Press of Virginia, 1998). MCVH was initially charted in 1838 at the medical department of Hampden-Sydney College in Farmville, Virginia, approximately sixty miles southwest of Richmond.

The Medical College of Virginia Hospitals' (MCVH) campus, with over fifty buildings occupying fifteen square blocks, overlooks the State Capitol and the

Governor's mansion. The campus constitutes the northeast corner of downtown Richmond's financial, governmental, and retail core. The Museum of the Confederacy is located directly behind MCVH and the visitors' parking deck for the hospitals is shared with the Museum of the Confederacy. The Confederate White House is the building most directly behind the Emergency Department. The academic, or west, campus lies twenty-two blocks away, just beyond the perimeter of downtown, in a picturesque, residential area of late nineteenth century townhouses. The west campus is bounded on the east by the city's Monroe Park and on the west by the Boulevard, on which are located the Virginia Museum of Fine Arts and the Virginia Historical Society Museum. The fan district, so called because of the way the streets separate or fan out as they move west, holds some of the city's most attractive homes, monuments, and buildings.

In 1854, ties with Hampden-Sydney were severed and the Medical College of Virginia became an independent medical school. In 1860, the state agreed to make the Medical College of Virginia a publicly supported institution. During the next 100 years it evolved into a major academic health sciences center and the largest hospital complex in the state's system.

VCU's academic campus began in 1917 as the Richmond School of Social Work and Public Health. In 1926, it became the Richmond Division and later the Richmond Professional Institute (RPI) of the College of William and Mary, another state-supported college. In 1962, RPI separated from William and Mary, becoming an independent four-year college, granting degrees in art, social work, business, and other fields. In 1968, the General Assembly merged RPI and MCV into a single institution and named it Virginia

Commonwealth University.

In the decades since the merger, VCU has emerged as a major force in American higher education, with more than 20,000 students and a planned maximum capacity of 22,500 in 1999. VCU is a comprehensive university with one of the largest and most diversified academic health sciences centers in the nation, the Medical College of Virginia Hospitals. VCU ranks within the country's top 60 institutions in research grants and contracts and offers 19 doctoral degrees, two first professional degrees (MD and DDS), 60 masters degrees, and 59 undergraduate degrees through its graduate school and its 12 colleges and schools. The university serves the local, state, national, and international communities through its scholarly activities, diverse educational programs, and public service activities. The university enjoys unique resources that enrich its programs and offers special opportunities for contribution to its intellectual and creative expertise in the development of innovative approaches to meet the changing needs of our society. The goal and mission of VCU is to provide graduate and undergraduate education which includes a broad and rigorous foundation of the arts, sciences, and humanities, and explores ideas and values of humankind.

Organizational Structure

The final authority for policies of the university lies with the Board of Visitors, each of whom is appointed by the governor for a specific term. The Board of Visitors appoints a president who serves as the Chief Executive Officer of the institution. The

rest of the university reports through the President to the Board of Visitors. For many years, MCV Hospitals served under the direction of the legislature of the Commonwealth of Virginia. In July 1997, the hospital officially became an autonomous authority with a board appointed by the legislature. The relationship with VCU did not end with that action.

The results of this transition are that the hospital will have greater flexibility in bidding on contracts, thereby allowing the life of VCU/MCVH to continue without incurring unnecessary deficits. However, the anxiety within the community is also raised because this is a change and it is private. The question from the community is: Will the same level of emergency and clinical care continue to be available to community residents? Assurance has been given that medical education and health care to the indigent will continue. Mergers are being formed with private physicians in the community to make their relationships stronger. Under the hospital authority, invitations are being extended for more involvement to African-American physicians. In the past, the number of African-American physicians was low. Historically, although many community physicians trained at MCVH, few were offered the privilege of practicing at MCVH. Several clinics in the city and in rural areas have opened to meet the general care needs of the patient who would otherwise have to travel long distances. It is expected that these early relationships with patients will enhance treatment outcomes.

The History of the Pastoral Care Department

The Pastoral Care Department was organized in 1943 when the Reverend Dr. George D. Ossman was employed as the first chaplain. MCVH's original vision was to provide not only pastoral care for patients and staff, but also pastoral care education. In order to fulfill this vision, Dr. Ossman spent several months during the next year studying with Dr. Roland Fairbanks, a hospital chaplain who taught Clinical Pastoral Education at Massachusetts General Hospital. Dr. Ossman completed his clinical pastoral educational with Dr. Fairbanks in 1944 and returned to MCV where he was both chaplain and pastoral educator for the next fourteen years. Many students from Union Theological Seminary in Richmond, Virginia, trained with Dr. Ossman during those years. In 1958, MCV made a firm commitment to develop a clinical pastoral education center, and the Reverend Dr. A. Patrick L. Prest, Jr., was hired to establish that program. In 1959, an accreditation visit was conducted under the auspices of the Association for Clinical Pastoral Education, Inc.

Dr. Prest was the first chair of the department until his retirement in 1992. He was succeeded by the Reverend Dr. J. Luther Mauney, Jr., a member of the department, who became the second chair of the department and retired in July 1996. After a national search for a new chair, Dr. Alexander Tartaglia became the third and present chair of the department in 1996.

Tenure of the faculty has been stable. Dr. J. Luther Mauney was a part of the MCVH Pastoral Care faculty for 27 years. Dr. Robert Young and the Reverend Marlyne

Cain have been a part of the faculty for over 20 years. I joined the faculty in the fall of 1993 after previously directing a CPE Center in Baton Rouge, Louisiana, at Our Lady of the Lake Hospital Regional Medical Center.

The Operation of the Pastoral Care Department

The Pastoral Care Department's primary mission is to provide spiritual care to patients and to offer clinical pastoral education to students. Accredited by the ACPE, we certify that the students are taught by certified supervisors with a curriculum that meets the standards and objectives of the ACPE (see appendix).

Students come from long distances to MCVH for training in our four programs of Clinical Pastoral Education. The full-time residencies are filled by Virginia residents, persons from across the country, and persons from overseas. Summer interns represent seminaries from many sections of the nation and foreign countries. Clergy and lay persons may travel over 200 miles to attend our evening extern program. Evening Clinical Pastoral Education is offered in the spring and fall to provide opportunities for men and women who cannot attend during the other two programs. A diverse group of our MCVH alumni practice as chaplains in institutions, as pastoral counselors, and as local pastors.

The staff of the Pastoral Care Department is ecumenical. Many different interests, experiences, and backgrounds are reflected in the staff of seven faculty members, seven resident chaplains, and two secretaries. Of the faculty members, three

are clinical staff chaplains and four are CPE supervisors. The department has the capacity to accept up to fifteen interns and externs in a total of seven units of training each year. Due to the nature of the program, students are constantly in transition. Residents provide the majority of the patient care because of their long term tenure, while the interns and externs, due to their short tenure, are not able to establish long term relationships with other staff.

The strong leadership of the three chairs and staff has enabled the department to continue to offer spiritual care to patients and hospital staff and pastoral care education to clergy and lay persons at VCU/ MCVH. In a time when downsizing or eliminating pastoral care has become the norm in many hospitals, VCU/ MCVH has not made drastic cuts in staff or closed programs.

I believe that the willingness of the pastoral care staff to meet the ever-changing needs of the hospital is largely responsible for the continued support they receive from the hospital and the university. With the advent of managed care and the focus on cost cutting measures, the demands of the hospital have changed. These inherent changes have caused staff deliveries of ministry and training for ministry to change. In particular, the increase in traumas and the acuity rate of illnesses have placed new demands on the pastoral care staff. To address these demands, several significant changes in the clinical environment were introduced in the past year. Among these changes is the establishment of two designated night-duty chaplains, which reduces the transitory nature of the duty chaplain. Previously "trained" interns and externs carried out this significant function alone and with a minimal amount of training.

The increase of trauma cases caused by violence in this community has increased the number of admissions of patients with intentional injuries to MCVH. Before 1992, motor vehicle accidents led the number of trauma admissions. With the increase in injuries from firearms, more injuries from violence are admitted to the hospital.

Nationally, the impact of violence is as follows: As of 1993, direct medical costs related to violence exceeded $5 billion annually. As of 1993, a substantial percentage of the estimated 1.5 million victims of assault were uninsured; their medical costs were passed on to taxpayers. As of 1996, public funds in excess of $100 billion per year were used to pay for health care costs from gun violence. Nationally, the current cost of direct medical services due to domestic violence alone is $1.25 billion annually.

The Associated Press printed a report (April 1996) by the Justice Department, using data from the Centers for Disease Control and Prevention, entitled, "Most Victims of Nonfatal Shootings in Crimes are Black," indicates the magnitude of the problem. This problem at VCU/MCVH is far above the national average since its rate of violent crimes is in the upper percentile nationally. (See appendix.)

In 1997, there were 140 homicides in the City of Richmond. At VCU/MCVH, 2,400 individuals were admitted with violent injuries serious enough for them to need a minimal overnight stay. Exact figures do not exist for those with violent injuries who were treated and released the same day. Statistical data concerning treatment for these patients is not kept. However, it is estimated that between four to ten times the number of individuals who stay overnight are admitted, treated, and released the same day.

Therefore, the possible numbers could be as low as 9,600 or as high as 24,000.

In either case, these are alarming numbers. The high incidence of violence has many non-direct effects on the population, families, neighbors, and the community. Since incidents of violence contribute to post-traumatic stress disorders of the victims, continued victimization and re-victimization is to be expected, in addition to the increased likelihood that current victims may become future perpetrators. Richmond's City Councilman, Anthony Jones, at a New Year's Eve memorial service made the statement: "This is a village that is broken." The severity of this problem calls for direct action by the entire community.

Summary

The Medical College of Virginia Hospitals is the context in which this model of pastoral care was developed. MCV/VCU is a university hospital that is rated among the top 100 in the nation. It began in 1860 for the purpose of providing professional medical care for the citizens of Virginia. It is a level one trauma center. The Pastoral Care Department is dually aligned with the hospital and the university and is primarily responsible for providing the spiritual care to the patients and staff of the medical college environment, which it has been doing for over fifty years. The department is accredited to offer Clinical Pastoral Education by the Association of Clinical Pastoral Education.

Richmond's crime rate produces an increase in the number of violent injuries to African-American males. Admissions through the emergency room department for traumas have increased with the increase of injuries from firearms. Prior to 1992, motor

vehicle accidents produced the largest numbers of trauma injuries.

Ministries in this setting require that chaplains have an understanding about traditional crisis care to patients and their families, understand the symptoms of post traumatic stress disorder, and be culturally sensitive to the needs of a diverse population. There are three very important things for chaplains to remember: 1) to be a non-anxious presence; 2) to express accurate empathy; and 3) to offer genuine concern. The chaplain is an essential member of the trauma team; therefore communication is essential to be a liaison between the medical personnel and families.

By following-up with surviving patients, chaplains may help the patient by hearing the account of the traumatic incident(s). When patients and significant family members are allowed to debrief, it is the beginning of the healing for the emotional and spiritual part of the person. It is important for chaplains to communicate an attitude of hospitality and welcome to all patients and families. The high incidence of violent injuries has caused a rise in medical costs for caring for victims of violence. Nationally, hundreds of billions of dollars are spent annually for caring for these young men, almost all of whom do not have any medical insurance. However, the Pastoral Care Department of MCVH treats each patient, regardless of financial circumstance or reason for admission, as an individual, a child of God, deserving of compassion, care, and concern.

CHAPTER TWO

LITERATURE REVIEW

Introduction

I have reviewed many articles that relate to care for trauma victims, such as post-traumatic stress in the mental health field. I have also reviewed traditional pastoral care literature. For this study, I have limited my review to materials that relate to crisis and the identity of the pastor. The other area that I have focused on has been on understanding the psychosocial conditions that lead to violence among African-American males.

The Christian Pastor by Wayne Oates

The Christian Pastor is a book by Wayne Oates that gives a very thorough review of the work of pastors, as well as the development of the pastoral identity and the role of the minister. This book largely relates to the function of pastors in churches. I have found this work to be helpful for new pastors, especially in the development of the pastor's identity. I was impressed that Oates addresses the issues of crisis ministry and provides an understanding of the variety of situations to which new pastors must respond.

The expectations are that the pastor will be present with individuals when they experience crises that represent the life cycle, such as birth, death, marriage. Accidents and injuries require the special attention of the pastor. Ministers are called because they represent the presence of God. Pastors are the embodiment of the love of God. The sustaining power of God's providential care supports the belief that God is within us.

Wayne Oates recognizes the presence of the Holy Spirit in the work of ministry. The pastor represents the symbolic power of the church. The pastor's authority needs to be handled with a great deal of care, especially in crisis situations when people are very vulnerable. It is important for the pastor to level the relationship by empowering individuals. The pastor is a reminder of Jesus Christ's suffering, the presence of God, and the hope of resurrection through the power of God.

The level of intimacy that Oates describes is given to the pastor and also the chaplain. He says that people in crisis need the following three basic characteristics:

1) accurate empathy

2) a non-anxious presence and

3) an inherent genuineness.

The psychological consideration here is called identification. This is the process whereby one takes on the feelings of another because of confidence and love for the other person and the desire to be with them. Identification on the divine-human level in terms of religious psychology is known as worship. I believe that our care of others is an act of worship. In ministry, if one approaches the individual person-to-person, fears of rejection diminish.

The Presence of God in Pastoral Counseling **by Wayne Oates**

In this book, the author clearly describes a process where the presence of God is the unseen member in the process of counseling, whether individual or group counseling. In Chapter 5, he discusses the presence of God in strange events and the stranger. He also discusses how the community of faith must be a welcoming community. "I was a stranger and you welcomed me" (Matthew 25:35 RSV). Also, "Do not neglect to show hospitality to strangers; thereby some have entertained Angels unaware" (Hebrews 13:2 RSV). In our emergency room at MCV hospital, we see people in trauma situations who are often very strange. Persons who come from different lifestyles, different ethnic backgrounds, and with different attitudes and values make up "the strange." They are "strangers" who have a sense of fragmentation and estrangement.

Oates' work explores biblical estrangements, such as Jacob wrestling with the angel that is found in Genesis 32. That story is about a family that is in crisis because of a rift between two brothers. Jacob prays and wrestles with an angel all night long. Family chaos is seen on a regular basis and sometimes it results in violence. The welcoming of the stranger is an opportunity for healing and reconciliation among families, which can occur in the midst of trauma. Families with fragmented relationships or a lot of anger and hostility come together in a waiting area, while the life of a loved one hangs in the balance between life and death. Sometimes these are opportunities for healing. For the chaplain/minister, it is an opportunity to join this family group in their

time of chaos.

People struggle in the midst of such chaos to find meaning or a blessing. Oates lifts up this idea of "stranger." "I have been in this dilemma more times than I'd like to remember. The presence of Christ here is not experienced as "sweet, sweet spirit in this place."[1] When I begin to feel profound repugnancies, I like to remind myself of what Moses said and did when he saw a strange phenomenon in a "burning bush." "I will turn aside and see this great sight, Why the bush is not burnt" (Exodus 3:3 RSV). To turn aside from my fixed and well-acquainted ways of doing things, understanding people and spirits, typically thinking, and to marvel at the strange phenomena my counsel or visitor has presented me is a discipline of great worth to cultivate. Edmond Hurl, from a much different philosophical framework, calls this gift the discipline of the naivety. Oates recognizes the importance of Hurl's philosophy and quotes him: "When we do not abandon these theses we have adopted we make no change in our conviction. When we set out as if it were out of our own action, we disconnect."[2] Being open to experience this, we assume a childlike attitude to open and welcome empathy of the strange persons sitting across from us. We make room for them in our world. As we do, we are promised that we will see the Lord Jesus Christ.

I can relate to setting aside my assumptions and my agenda for the moment to explore with people what it means to be in their crisis situation and to journey with them

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[1]Wayne Oates, *The Presence of God in Pastoral Counseling*, (Waco Texas: Word Publishing, 1986), 61.

[2] Oates, *The Presence of God in Pastoral Counseling*, 61.

and witness the presence of God. It is my goal to make the strange place less strange and to make the stranger a new, welcomed friend.

In Chapter 7, Oates talks about the presence of God in darkness. My relationship to this idea has been a tremendous learning experience in finding how God is present when people are at their worst. Some of the cases that are presented here represent spiritual experiences that victims have had in the midst of their crisis. Oates talks about this, the presence of God in darkness. Some people live their lives in quiet desperation. To them, God's presence continually alludes them in the dark night of their souls.

The pastoral counselor, as he/she listens to people express their real feelings about the presence of God in their lives, hears these kinds of expressions more often than we hear such resounding testimonies as, "There's a glad new song singing in my heart, such as angels would sing above the whole day long." It takes a long time before some people are able to express that. It is exclusively with the chaplain that many patients have shared their feelings of the dark night of the soul.

It has been in these dark, dark places that I have experienced and concurred fully with Oates' assessment, that in these dark places God is indeed present. It is my experience that these "dark nights" have been expressed with one young man who states, "God stood with me through the midst of the trauma, when they thought I would die. It was God who coached me to 'hang on' and to stay."

Oates goes on to talk about rage. He makes us somewhat more comfortable with what is rage, by quoting from Psalm 109. That is a prayer about rage. It is a comfort for me to know that the psalmist also raged. Many times we encounter individuals who are

angry and, in fact, in a rage. That is the primary reason why they are in the hospital, because rage has taken the form of violence. It is in the midst of their rage that care is offered.

Oates describes the community of faith as a place of healing. It is my belief that we need to be able to create and be a part of a holistic healing for body, mind, and spirit. The young African-American males who enter our doors often go out with their physical bodies repaired, but they have no healing community which embraces them. This is indeed a tragedy.

The Minister As Crisis Counselor **by David K. Switzer**

This book covers a variety of ways the minister might understand his role in the crisis. He mainly speaks to a minister from a local church addressing a homogeneous group. He also talks about the involvement of the minister as a counselor to a community in crisis. He advises them to look at ways that they might be effective. Because of the date, time, and context for which Switzer writes, he does not mention stress or the effects of post-traumatic stress in the community. Before the 1980s, post-traumatic stress was generally relegated to military life, resulting from combat, as opposed to the current ways in which we experience stress now in our communities. Switzer's model would not address the types of violent crimes that we see. He does not directly address this particular problem. However, his concept of the use of the congregation to address crisis is helpful. His work provides theoretical foundation, but is

lacking in its practical application for our context.

Switzer's discussion about accurate empathy gives three ways of being with people that are effective. The first one is that it is important to accurately empathize with people and to be able to accurately reflect that empathy. The second is to understand and feel with the other and to allow that to be expressed. Empathy must be communicated verbally to be effective. This is an important dynamic and is very useful in my particular context. For one to be empathic, without having the ability to communicate that to victims or families, means the empathy is lacking in its effectiveness. Many times we see individuals who are attempting to offer care, but can only wring their hands, rather than offer any words of consolation. While it is necessary not to use this as a teaching or preaching moment, it is important to be able to accurately empathize and express that empathy.

African-American Pastoral Care by Edward P. Wimberly

This book utilizes storytelling narrative theology to offer pastoral care. It is through the stories from various resources of what Dr. Wimberly calls "non-conflictual" stories that clients are allowed to receive care from Bible stories, stories about life, and also to be heard for the value of their own story. The cases that he reviews are of a local church that utilizes stories to help a patient discover resources to confront his addiction. These stories were used as worship in prayer services to promote deliverance and recovery. It is to Dr. Wimberly's credit that he boldly affirms the traditional African

means of communication in the African-American community. He does not limit his counseling technique to stories, but uses them as the main paradigm in addressing needs.

Soul Stories: African-American Christian Education by Anne Straightley-Wimberly

Soul Stories: African-American Christian Education contains stories that have been collected from the author's interviews using the process of story linking to help people move toward liberation through the understanding of their history and how that history affects their development as Christians. The author's view of liberation embraces a belief system that helps one to overcome life's problems. Utilizing their values, their heritage, and their faith, these stories are inspirational as well as productive curriculum and activities for groups. Individuals identify with life's issues from the cases presented.

Stages of Faith Development and Pastoral Care by James W. Fowler

In this book, Dr. Fowler addresses the eight developmental stages that are set out by Erik Erickson, and he looks at how these are found in the spirituality of individuals. The way that he uses these stages does not necessarily denote an individual's chronological age, but rather his/her spiritual and emotional development. This formation comes as a result of education and/or life experience. It is important to be able to make assessments about where an individual is spiritually so pastoral care will meet their needs. I believe this is a significant work in helping pastors make appropriate

assessments. It may also be a guide in assessing one's own spiritual life. Specifically, it is important in my work to look at how this differs with people that are oppressed and who are experiencing traumatic stress disorders. Stressful times serve to help individuals mature spiritually and develop emotionally.

From Ministry to Theological Pastoral Action and Reflection by John Patton

In this book, Dr. Patton looks at the value of relating to human experiences in actual life situations by utilizing what is called in clinical pastoral education, "the living human document." He describes how sharing experiences in a non-threatening way can build community relationships and allow groups and individuals who come from different perspectives and backgrounds to transcend their differences, to allow for growth in ministry.

Dr. Patton affirms that we need to share our story. It is in sharing our story that we become known. We need to understand and claim the events in our lives that have shaped who we are. By interpreting our stories, important aspects of our own theological framework are developed. In my practice as a clinical pastoral counselor supervisor, I have used theological integration to help understand and develop theological ways of thinking which utilize the social, psychological, and theological perspectives to integrate the message of the whole person.

Wounded Healer by Henry Nouwen

Wounded Healer by Henry Nouwen is now among the classics. Nouwen raises the question of what it means to be a minister in a contemporary society. He explores the answer through four "doors": 1) the condition of a suffering world; 2) the condition of a suffering generation; 3) the condition of a suffering person; and 4) the condition of a suffering minister. Through the condition of a suffering world, Nouwen explores our human predicament as having lost faith in the possibilities of life and the trade-in for technology. While technology is very powerful, it is also lacking in enabling humanity to reach its creative possibilities.

Nouwen explores the condition of the suffering generation and views it in a convulsive upheaval with the family torn upside down and fragmented. In looking for balance, the tendency is to direct pain at one another and to turn on each other. Henry Nouwen reminds us that God is still at work, and ministers can be helpful as guides in helping the world fight its battles. The task for the minister is to bring hope in an otherwise tremendously hopeless situation of the suffering person, but not to impose or to change the painful situation. The minister must be aware of his own wounds and allow these wounds to be their own wounds. In ministry, one must be prepared to heal the wounds of others and be a witness to the living truth that the wounds that cause us to suffer can be healed because God is a part of the healing process. Ministers are called to have an attitude of hospitality that allows others to enter the minister's life through the intimate contact of those who are fellow sufferers.

***Pastoral Counseling Across Cultures* by David W. Augsburger**

Pastoral Counseling Across Cultures will enable all counselors to understand the cultural differences and dynamics of different individuals. This book explores eight different cultures and is sensitive to gender and generational differences. It offers multi-cultural awareness and sensitivity to diversities for the counselor to help as a healer to individuals and families. It has a solid theological foundation and seeks to ultimately develop healing communities.

***A Troubling in My Soul, A Women's Perspective on Evil and Suffering* edited by Emilie M. Townes**

This book is a collection of essays by African-American women representing a variety of voices on the critical issues that effect African-American life in urban and rural communities. This work covers slavery through the present day with issues that affect mainly racism, ethics, and oppression. It is a powerful force that was helpful in understanding my work with the victims of violence. While my work focuses on African-American males, many are in families that are headed exclusively by women. The contributions from this work are enormous because it helps to clarify the historical condition of African-American women and their contributions to family life and culture.

Soul Theology, the Heart of American Black Culture

by Nicholas Cooper Lewter and Henry Mitchell

Soul Theology, the Heart of American Black Culture contains thirty cases that offer an understanding of how one's belief system either provides a healthy emotional balance or is inadequate for balanced mental health. These are all influenced by one's core belief system. A person's deepest beliefs about God will usually heavily influence, if not totally determine, his or her mental illness or wellness. Some core beliefs help people survive and cope through tremendous tragedies, while others' belief systems do not provide that kind of foundation. This is an important work that utilizes the stories of African-American peoples.

Summary

In the course of this study, I reviewed many articles related to the problems of violence among African-American men, and the problems of violence, often with firearms, that resulted in intentional injuries. Although other weapons are used to cause harm and death, the most efficient killing tool is an automatic firearm.

I did not find any articles on models for spiritual care to victims of violence in a general hospital/trauma center. A project sponsored by Kaiser Primate in San Francisco, entitled, "Take a gun and save a life," describes how physicians participate in a community-led effort that includes churches to reduce the number of guns that are available on the street.

There is a large body of literature from the United States military that describes

treatment of victims of violence with post traumatic stress disorder. Some articles deal with spiritual care, however the victims are all enlisted persons. Since the armed forces represent a homogeneous subculture that has traditional support for victims, their care and needs are different from the civilian population. While information from that source was enlightening, it only related indirectly to the problem of intentional injuries that occur from the street crimes that we faced at MCVH.

I utilized traditional pastoral care literature, but focused on crisis ministry, the identity of the minister, and the presence of God in pastoral care. Narrative theology places a contemporary, cultural understanding for merging traditional pastoral care which I found useful to form this model of ministry.

Books and articles from the behavioral sciences, especially for mental health, provided a lot of material on post traumatic stress disorder and ways of counseling victims of violence. Stage-oriented post traumatic stress disorder was helpful in considering stage one of stage-oriented debriefing—listening to the person's story and helping them discover their own spiritual resources. This technique is not new to pastoral care. However, looking at it from the post traumatic stress disorder model was new and proved to be helpful with the particular group of patients. Overall, combining resources from three sources, 1) traditional pastoral care in crisis ministry, 2) narrative (descriptive theology, listening to the person tell their story and integrating it into their life story), and 3) behavioral sciences, i.e., mental health and psychology, was helpful in understanding how to integrate counseling for African-American male victims of violence.

CHAPTER THREE

THEORETICAL FOUNDATION

The focus of this work is how African-American males, ages 18-35, are affected by violent injuries. Pastoral care of victims of violence is based upon a theoretical foundation which incorporates pastoral care with special emphasis on crisis ministries and post traumatic stress disorders. Over the past five years, violent injuries and homicides have risen to epidemic proportions among African-American males. This project is offered to chaplains who work in institutions that offer care in emergency rooms and trauma centers. It is also intended for pastors and lay persons in congregations who will benefit from this work because it will increase our understanding about the individuals who have experienced the trauma of violent injuries.

An intentional injury is one that is caused by the direct action of another person with the intention to kill or harm the victim. Weapons range from fists to the now popular automatic handgun. Injuries from firearms produce the largest number of injuries. The trauma resulting from these injuries results in an intense level of stress to victims and their loved ones. Post traumatic stress disorder symptoms, as described in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III-R),

1987, are apparent. The DSM-III-R provides a diagnostic classification for the long-range effects of psychological trauma, defined as follows:

> When a person survives a catastrophic incident there may be residual trauma and stress reactions for years. Many persons who experience long-term stress reactions continue to function although possibly at a less than optimal level. Stress reactions are the NORMAL response to a traumatic event. Those who are unable to function at normal range, or who are experiencing difficulties in one or more areas, may be diagnosed as suffering from Post Traumatic Stress Disorder (PTSD). Due to the nature of the crisis and the possibility that grief reactions my have to be repressed and delayed due to demands placed on the survivors by the court system, the diagnosis of PTSD and Delayed Grief may be evident in survivors of homicide. [3]

Recognizing the symptoms of PTSD helps chaplains to be sensitive to the needs of victims and family members. Integrating crisis care and the first step in stage-oriented post traumatic stress model (debriefing) is a helpful way for these two theories to complement each other. Both paradigms use the patient's story to help them sort out the events that have taken place and try to make sense out of the tragedy that they are experiencing.

Individuals are not emotionally prepared to cope with the events of intentional injury or homicide. Few individuals are emotionally prepared to deal with the impact of these traumas, nor do they have sufficient coping mechanisms to inoculate themselves from the pain. If individuals show little or no emotions, usually it is because they are numb or in shock.

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[3]The Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised, (DSM-III-R), 1987.

Post Traumatic Stress Disorder 309.89

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently re-experienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
(2) recurrent distressing dreams of the event
(3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative (flashbacks), episodes, even those that occur upon awakening or when intoxicated)
(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma[4]

Social Impact of Intentional Injuries on Communities

The increase in violent injuries on communities is related to new and improved technology in weapons. Firearms have increased in firepower and in speed. More damage may be caused faster to more victims. Nationally, African-American males are 125 times more likely than white men to be murdered on the street. The cost of medical care for intentional injuries is overwhelming. Over one hundred billion dollars was

[4]DSM-III-R, 1987.

spent in 1996 to treat victims. In addition to the initial medical cost, the cost of ongoing care for persons with major physical disabilities, disfigurement, and acute psychological traumatization, and the cost of death impact the country, with the loss of the possible contributions of these men. For years it has been written that the African-American male will soon be obsolete. At the present rate of homicides, injuries, and incarcerations, it is possible for this to happen.

My findings reveal that the number of men who are affected is in the millions. This affects their future productivity, their children and family members who will care for them as well as the society at large. The other loss is the Spiritual rupture that is experienced because of this loss. That is not a fact that I am able to measure, but I am aware that it exists.

The study of the impact on children with injuries, found that in 1996 there was an increase of 270% more injuries to youth. (See appendix - The Children's Defense Fund Report.) The increase of drug use in the African-American community is at a record high. Drug transactions are the cause of many violent injuries. The use of drugs themselves reflects hopelessness and despair. The use of drugs is an effort to anesthetize pain. This problem is growing. The increase in drug use terrorizes communities that are openly controlled by lawlessness. In neighborhoods where lawlessness prevails, drugs are sold in "open-air drug markets" and known crack houses exist. Youth who are involved in the distribution and use of drugs are becoming younger. Daily children witness violence in their homes and neighborhoods. The affects of this constantly exposes them to possibilities of post traumatic stress disorder.

Newsweek Magazine, July Edition, 1996, reported that some injuries of victims of violence cost the country and state an estimated $500,000 per incident. That article featured a drug dealer who was uninsured who was found with a large sum of cash in his pocket at the time of his injury. He had no insurance and certainly not enough money to pay the cost of his hospitalization and after-care. This is a problem that is repeated regularly in major hospitals throughout the country.

The Hospital as a Caring Place

The Medical College of Virginia Hospital receives victims in the Emergency Department. These victims come in with a wide variety of injuries. A duty chaplain is on-call in the hospital seven days a week, twenty-four hours a day. They are a part of the "trauma team" that cares for the patients. They respond to the trauma team alert that goes out on the paging system. The chaplains are there, with other health care professionals to help people experience the hospital as a healing place. Care is carried out in an atmosphere of stress and excitement. A well-orchestrated medical team assesses the patient's condition and seeks to get them to the operating room or in stable condition as quickly as possible. While the medical staff is taking care of the needs of the patient, the chaplain assists the family and offers support to the victim. The chaplain helps families with immediate needs and provides an atmosphere of support for them. Offering care to families of victims is difficult because of the highly agitated conditions under which many enter the hospital, resulting from the loved ones injuries.

A spirit of anger and resentment is often misdirected, spilling over onto others. Chaplains who enter into these relationships need to be a healing source to address the initial feelings of anger, outrage, fear and pain.

The Identity of the Chaplain

It is important that the chaplains understand who they are, their own story, and that the issue of transference and how their own woundedness affects how they offer care. It is important for them to address their own pain and parallel issues in their lives before attempting to minister to others. It is important for chaplains to offer care as early as possible to patients and family members. The presence of the chaplain is a reminder of the presence of God. Remembering that God is present, helps individuals who are very vulnerable go to their primary belief system. When crises arise, most people believe that God will be with them. Experiencing the presence of God brings about a more peaceful environment in the midst of the chaos. These situations require ministers who can approach the suffering of others as a "wounded healer." This is applicable because the wounded healer is not a care giver whose task is to take away pain, but rather the wounded healer helps deepen the pain to a level where it may be shared.[5] When pain is shared, it is less likely to be turned into rage or revenge.

This theoretical foundation utilizes narratives, storytelling and theology. The "story" is primary in offering the care. To listen to what has happened and to hear how

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[7]Henry Nouwen, *The Wounded Healer*, 1972

it affected the one who is telling the story lessens the feeling of isolation. Chaplains identify with the experience of others at many different levels. Some reflect upon their own story and identify with individuals in this trauma situation because of their own pain. Their own story may have similar painful feelings such as abandonment, abuse, alienation, anger, and aloneness. Although the details of their story may be different, they empathize with the parallel feelings of the individual in crisis.

When injuries happen to an individual, they may feel alone. When two or more persons share their pain, it becomes a human experience that is often visited by the presence of the Divine. Pastoral care in this situation becomes God's work in the midst of tragedy.

Since 1995, I have served as a chaplain on Main 9 Central, a medical surgery floor at MCVH, where most of the trauma patients come after leaving the intensive care unit. At first, my idealism led me to believe that the chaplain's influence would help to reduce re-victimization and assist patients in leading successful lives. I still believe that spiritual care makes a difference.

The values found in some of these patients represent the new subculture that is involved in crime and violence. I find that these frightened young men have been written off by many levels of society. They lack education, are unemployed and now injured. The work of Dr. Edward Peebles on intentional injuries, suggests that gunshot wound victims present to a medical facility for care on an average of four times before they return with either a mortal wound, or a brain or spinal cord injury. I believe that when spiritual care is offered it can help to reduce further victimization and lead to

healing and hope.

The use of the narrative model helped patients explore the impact of their injuries. Telling their stories often allowed them to experience themselves as persons of worth and value in spite of the terror they feel and the devastation of their injuries. Some victims realized that the presence of God was with them as protector and savior. This understanding of the event is the beginning of emotional healing. It can provide strength through the recovery process and help them to reevaluate their lives and change their life styles.

Theology–The Biblical Imperative about Violence

Murder and crime are as old as the human community. The book of Genesis records the first murder between Cain and Abel.[6] Jealousy was the issue between these

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[6]Chapter 4:3-16 RSV. In the course of time Cain brought to the Lord an offering of the fruit of the ground, and Abel for his part brought of he firstlings of his flock, their fat portions. And the Lord had regard for Abel and his offerings, but for Cain and his offering he had no regard. So Cain was very angry, and is countenance fell. The Lord said to Cain, "Why are you so angry, and why has your countenance fallen? If you do well, will you not be accepted? And if you do not do well, sin is lurking at the door; its desire is for you, but you must master it. Cain said to his brother Abel, "Let us go out to the field." And when they were in the field, Cain rose up against his brother Abel, and killed him. Then the Lord said to Cain, "Where is your brother Abel?" He said "I do not know; am I my brother's keeper?" And the Lord said, "What have you done? Listen, your brother's blood is crying out to me from the ground, which has opened its mouth to receive your brother's blood from your hand. When you till the ground it will no longer yield to you its strength; you will be a fugitive and a wanderer on the earth." Cain said to the Lord, "My punishment is greater than I can bear! Today you have driven me away from the soil, and I shall be hidden from your face; I shall be a fugitive and a wanderer on the earth, and anyone who meets me may kill me." The Lord said to him, "Not so! Whoever kills Cain will suffer a sevenfold vengeance." And the Lord put a mark on Cain, so that no one who came upon him would kill him. Then Cain went away from the

brothers. Abel's offering was acceptable by God and Cain looked at his offering to God and became angry and jealous. Cain decided that he would kill Abel. This is the first murder in the Bible. The breach between the two brothers was more than death. It also caused the breach between God and his creation. However, what is shown here about God and the Biblical imperative are clear from the Genesis account, that God became the initiator of the healing process. God came looking for the perpetrator, Cain, and asked the question, "Where is your brother?" The biblical imperative to the church and to the community as violence is perpetuated is, "Where is your brother?" God's protection and compassion are seen in this passage as He puts a mark on Cain and sends him out into a world that is violent and may take his life. That mark becomes a protection for the people of God. This story's dynamics about God's protection with the mark that Cain received raises the question, "If God could protect us from harm, why has God allowed the perpetuation of violence?" The problem of suffering and evil are a part of how we experience God.

The Bible, as recorded in the books of Leviticus and Deuteronomy, calls for the cleansing of evil from the community. It requires the community to act in a positive way to remove crime. Death is the required punishment for those who break the law through murder. Of course, mitigating circumstances are issues in the Old and New Testament. One of the Ten Commandments says "Thou shall not kill;" another commands the community to act in positive relationship toward neighbors.

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presence of the Lord, and settled in the land of Nod, east of Eden.

These commands set the standards that God Almighty expects. In the New Testament, on the other hand, there is a shift in attitude: God has decided to be on the side of the "have nots" and on the side of the victims. The parable that Jesus tells about the Good Samaritan is found in Luke 10:27-37 KJV.[9] The Good Samaritan was motivated to act on behalf of the victim, while others ignored him. The Levite and the Priest passed by on the other side. They lifted their long robes and moved to the other side. Their religion warned them not to come in contact with a dead body because it was a violation of the Levitican law. The priest was considered kind to offer a prayer for the victim from a distance. The Samaritan was a person of a different nationality. He was truly the neighbor because he came to the aid of the victim and applied immediate assistance. He put him on his own beast and used his own wine and oil to anoint the victim. He washed the wounds and injuries of the victim who was thrown into the ditch

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[9]And he answering said, "Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy strength, and with all thy mind; and thy neighbor as thyself. And he said unto him, Thou hast answered right; this do, and thou shalt live." But he, willing to justify himself, said unto Jesus, "And who is my neighbor?" And Jesus answering said, "A certain man went down from Jerusalem to Jericho, and fell among thieves, which stripped him of his raiment, and wounded him, and departed, leaving him half dead. And by chance there came down a certain priest that way, and when he saw him, he passed by on the other side. And likewise a Levite, when he was at the place, came and looked on him, and passed by on the other side. But a certain Samaritan, as he journeyed, came where he was, and when he saw him, he had compassion on him, and went to him, and bound up his wounds, pouring oil and wine, and set him on his own beast, and brought him to an inn, and took care of him. And on the morrow when he departed, he took out two pence, and gave them to the host, and said unto him, "Take care of him, and whatsoever thou spendest more, when I come again, I will repay thee." Which now of these three, thinkest thou, was neighbor unto him that fell among the thieves? And he said, He that shewed mercy on him. Then said Jesus unto him, "Go, and do thou likewise."

and took him to an inn, where he paid the inn keeper to take care of him, with a promise to repay any additional fees on his return.

This passage clearly shows Christ's imperative to express care to victims. I believe that providing care to victims is the mission of the church. We must offer care with dignity and the love of the Lord.

When I see young men being brought into MCV extremely violated and broken and in a totally vulnerable condition, it clouds one's understanding that these men are also wonderfully made in the image of the Almighty God.

When a person's dignity is reduced to zero, it is difficult to see them as worthy of honor. The way in which the patient and his associates are viewed is an extremely important aspect of caring for them. If these individuals are seen as merely another worthless drain on society's already limited resources, it is impossible to offer compassionate care. If the person being cared for is not valued, compassionate care cannot be offered. The chaplains need to look beyond what they see in a person's present situation of victimization and recognize them as valued human beings with all of the potential that God has given.

Identifying the victim as quickly as possible is the beginning of restoring some level of dignity. As long as the victim is nameless, he is more likely to be treated as an object or non-person. An example of how important identity is was made explicably clear to me when I was in the emergency room. A 30-year-old African American male was brought in. He had a gun shot wound to the chest. The trauma team immediately began to work frantically to save his life. Someone shouted, "He is dry!" meaning that

he had nearly bled out. Doctors cracked his chest and began to administer blood to his heart directly. Doctors also massaged his heart to stimulate its activity. The police and other non-medical personnel looked on. Some of us wondered why what appeared to be futile treatment was being done. I continued to watch. What I saw was absolutely incredible. His heart started to beat. The patient, who was still only identified as Mr. X, surprised everyone by opening his eyes. Looking into his beautiful brown eyes I could see a host of other black men. At that moment, he became a person. He was rushed into surgery, although his identity was unknown. Yet, he was more than Mr. X to me. He could have been my brother or son. His identity was later found and his family notified.

The connection of the man to a family made a significant difference. They told his story. The dignity of identity was restored. He was no longer a nameless member of society, but a man. All consideration was given to him. Listening to the family tell his life story and caring for them made a difference. He died later that night, but not as a "Mr. X."

In Dr. Na'Im Akdar's book, *Breaking the Chains of Psychological Slavery*, he offers the idea that the impact of slavery has affected African-Americans collectively because of 300 years of slavery. He explores how many negative traits, including violence, are still in the culture[10]. The primary cause that he points to for violence is

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[10]History cannot be reversed and this review of the circumstances of the slavery of the African-American was not intended to be the completion of this analysis. The 300-year captivity of Africans in American is an in disputed fact which too many have sought to deny as about anything more than an event of the past. Our formulation suggested that the blemish of these inhumane conditions persists as a kind of post-traumatic stress syndrome on the collective mind of Africans in America and though its original cause

self-hate.

My work with victims has helped them explore their current trauma in light of many other traumas that they have experienced in their lives. In *Breaking the Chains of Psychological Slavery*, Akdar states on page 25, "Helping patients tell their story is producing many opportunities for healing."[11]

Personal Transformation

As our peer group worked on this doctor of ministry degree, Dr. George McRae, in one of our peer sessions, commented on my context analysis. He pushed me to become aware of my own reasons and motivations to work with this particular patient population and their families. He helped me to become authentic with my own grief.

Why was I grieving? My Uncle Clyde died after a mugging. My cousin, Hiram III, died after a single gunshot wound to his head and was left in a car to bleed to death

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cannot be altered, the genesis can be understood. As is accepted in most insight approaches to mental healing (calling psychotherapy), a confrontation of the original trauma and a restructuring of the mind's faculty and adaptations to the assault can serve to correct these disturbed patterns of responding. The book was intended to offer insight into what had been collectively denied by the entire society as having any relevance to the psychological functioning of African American people. With this insight, we believed that internal healing could begin.

[11]However, the fact remains, the "plantation ghost" still haunts us. Our progress is still impeded by many of the slavery-bases characteristics which we have described previously. The objective of the discussion is not to cry "victim" and seek to excuse those self destructive characteristics created by slavery. In fact, the objective is to identify the magnitude of the slavery trauma and to suggest the persistence of a post-slavery traumatic stress syndrome, which still affects the African-American personality. It is not a call to vindicate the cause of the condition, but to challenge Black people to recognize the symptoms of the condition and master it as we have mastered the original trauma.

and die alone. My cousin, Sandra, died as a result of a domestic beating. My cousin, Paula, was brutally bludgeoned to death and her body left for months in an alley. Undiscovered until after the snow melted and people began to smell a foul odor, her body was discovered and later identified by her mother.

My grief in these experiences has remained unresolved. With each of these experiences, I was unable to attend the funerals, even after traveling from New Orleans, where I was living, to my hometown of Cleveland, Ohio. After attending the wake service, I missed the actual funeral for my Uncle Clyde because my husband, DeForest Brown, was traveling in Washington, D.C. and suffered a stroke. I had to leave before the funeral to go to my husband. Despite the dual crisis, I know that I made the right choice. Yet, my grief was left unresolved. The funeral rites would have provided me with some ability to move through the grieving process in a more natural way. This was stifled. Constantly addressing grief in the hospital added to my own unresolved grief that was becoming more painful. My feeling of anger, with the awareness that some victims were disrespected because of race, value conflicts, and so forth, was becoming a barrier to my looking at the situation holistically.

Dr. McRae helped me to become more authentic about the possibility of transference. Recognizing my identity with them was confrontational. Seeing this removed the conflicts and shame that I felt. I could see persons as wonderfully made children of God.

In pastoral care, I experienced the hostility and resentment of young black males who have been "dissed" (disrespected) by this society. I realized that I could no longer

stand at a distance and point my finger in a self-righteous mode about the way others demonstrated biases. I became authentic with where I stood. With God's help, I can say that I stand as God's representative on the side of suffering people. Understanding my part in corporate evil that is inherent in violence, that is found in the African-American community illustrates that many of us are culpable. Violence. Why does it happen? Why does it exist at this level among our people? I confess that I do not know all of the reasons for the violence, but coping with personal anger helped me to minister more effectively to others. The theology that I utilized is based upon respect for the intrinsic value of every person.

The personal growth occurred as I witnessed the presence of God in my own unresolved grief. Being aware of verbal and non-verbal violent ways of communicating caused me to be more sensitive to how I may personally victimize others. Also in understanding that the underlying racism that is inherent in MCV and our community causes both internal and external conflicts, it is essential not to compromise my own integrity to survive. Journeying with survivors, I experience that healing is taking place in me as well as in the victims of intentional injuries and homicides and their families.

Summary

The Theoretical Foundation provides an understanding about the problem of violence from several aspects. God's interaction shows God's interest in how violence affects relationships among individuals. The incident of Cain killing Abel showed God' s involvement when He called Cain to accountability for the murder of his brother. In

spite of Cain's guilt, God still demonstrated love for him. In the New Testament, the story of the "Good Samaritan" teaches the value of showing care for victims, even if showing care is an inconvenience or risk.

The social effects of violence upon the African-American community are costly— emotionally, spiritually, and financially. The long-term effects of violence are devastating to the communities' development and progress.

The ideas that Dr. Na'Im Akdar advances in his book, *Breaking the Chains of Psychological Slavery*, suggest that post traumatic stress collectively affects African-Americans because of the effects of the 300-year captivity of African-Americans in this country. The fact of this original trauma and other effects of slavery remain central to the pathological behavior of many African-American males.

The symptoms of post traumatic stress etiology of post traumatic stress disorders are found in the original traumas that result from earlier victimization, often before the injury for which the patient is admitted to the hospital. When the victims tell their stories, it is common for early experiences to be discussed. When the chaplain debriefs about the current incident, healing for past victimization is also possible.

This chapter addresses the attitudes of the chaplains who offer ministry to victims of violence. Their attitude must be one of values and acceptance of others. This includes those in authority and victims and their families who are in a broken, devastating situation. Chaplains need to be sensitive to racial, cultural, and religious diversity of patients and families.

CHAPTER FOUR

MINISTRY REPORTS

"Mr. S."

Visit with Patient S. **Chaplain E. G.**

Situation: Pastoral Care **Time of Visit: 10:40a.m.**

Diagnosis: Gunshot Wound **Date of Report: 12/11/97**

Factual Data

I initially met Mr. S. during routine visits on my assigned floor, M9C. Mr. S. is a 22-year old African-American male who had been admitted to MCV on November 11, 1997, due to gunshot wounds to the back, which had immediately affected feeling in his legs and left arm. Mr. S. is single, however, he does have one son, who is a year old, and a fiancee, T, who is very attentive to him.

Observations

Mr. S., a seemingly small-framed young man, was sitting in the hall just outside his hospital room, propped on two pillows. He exhibited a broad smile when he saw me, as if he was glad to see me or someone in the ministerial role. The one thing I found striking about Mr. S. was his teeth. His front teeth are all gold caps or open-faced crowns. He appeared very alert, yet when he was not smiling, he seemed very sad. Mr. S. continuously handled his right arm gently by rubbing it or holding onto it.

The Visit

C1. Mr. S., hi, how are you this morning? I am Chaplain G. I am glad to see you up. I stopped by to see how you are doing this morning.

P1. I am doing alright, except for the pain in my back and my arm.

C2. Mr. S., it seems you have really gone through a lot and even experiencing some difficulty right now, but you have come a long way in your physical healing and each day you will get even better. Don't you feel good about that?

Pt2. I know, Chaplain G. It's not going to be this way always. Look, can you come back to see me? I don't feel like talking anymore right now. But I do need a Bible if you have one. I feel like I need to get into God more.

C3. Your spirits do seem to be a little down right now and I understand your need to be alone, Mr. S. As you said, it's not going to be this way always. So maybe in a day or two you may feel even better and feel like talking. In the meantime, I am here for you. Okay? I will go down and get a Bible for you. But, before I do, would you like for me to have prayer with you?

Pt3. Yes, ma'am, that would be good. My girlfriend left a prayer note in the chapel. Did you all read it?

C4. I am sure it was read and prayer was offered. (At that point, he reached out to me and laid my hand on his infirmed hand. I prayed for healing for Mr.S. physically, emotionally, and for healing of his spirit. He began to cry. We ended our prayer with the Lord's Prayer. After a brief silence, I could feel Mr. S. relax as I continued to offer presence. I eased my hand from his and I left to get the Bible

with a promise to return. Upon my return with the Bible, I found Mr. S. nodding in his wheelchair. I touched him and offered the Bible. He thanked me and asked me if the Lord's Prayer is in the Bible. I assured him it is. I then turned to the appropriate passage and marked it for Mr. S.)

Pt4. Thank you, Chaplain. Thank you for coming to see me. Will you come back to see me again?

C5. Why you are certainly welcome, Mr. S. Of course, I will come back to see you again. In the meantime, you be blessed. (With that I left him in the hallway beginning to nod again.)

Follow-Up Visit

Several follow-up visits were made to Mr. S. It was during one of those times I got to meet his son and fiancee who proved to be a very striking young lady and seemed very attentive to Mr. S.

On the morning of 12/6/96, I visited with Mr. S. on a follow-up visit before he was to be taken to the Rehabilitation Unit. Mr. S. was somewhat cheerful and glad to see me.

Pt1. Hi. Chaplain G., right?

C1. Why, yes, Mr. S. I see you remembered my name. How are you doing today?

Pt2. I am doing a little better, but you know, the doctor says I will never walk again. I don't understand. I just don't understand, Chaplain G. (Mr. S. seemed somewhat

bewildered.)

C2. (I placed my hand on his shoulder.) How does that make you feel? The doctors comments, I mean? What is it you don't understand, Mr. S.? Is it what happened to you, or why it happened, or how it happened, or what?

Pt3. All of it. I will not walk again. But I don't want to talk about it right now.

C3. All right, Mr. S. Maybe we will talk at a later time. You also seem a little angry right now. It will do you a world of good to talk things out and even address your concerns to your doctor so that he might explain to you fully, in a way that you might understand him better. I am here, of course, to listen and I will be here whenever you care to share what is really troubling you. If you should feel the need, call me later. In the meantime, Mr. S., I will be praying for you that God will grant you the understanding you need to lessen the turmoil and anger you must be experiencing at this time.

At approximately 6:45 p.m. on that same evening, I was called to N1 to visit with a patient. Upon my arrival, I was asked to see a Mr. S. After receiving permission to enter, I encountered Mr. S., who was lying on his bed slightly on his left side. His fiancee was also present and seemed a little upset. She stated that the doctor had explained to her that Mr. S. would not walk again.

T1. Chaplain, I am so glad you could come to see us right away. S. is really down this evening. The therapist has just left, and he is just so sad and scared, fearful,

you know. He woke up a short while ago in a deep sweat.

C1. Mr. S., what's wrong? What can I do to help? Why are you so fearful?

Pt1. Chaplain G., have a seat. I have these dreams. I dream I am walking. When I woke, I thought I moved my leg. I think of how I could have been dead. I could have left my son. I go to sleep and deep inside of me I feel I will walk again. I feel like God is punishing me. I have done a lot of things, Chaplain G. I used to keep a lot of money and everything. That's why they tried to rob me. I fought and tried to run and after awhile I could not feel anything. And I just feel sorry. I just hope God forgives me and saves me and my little boy and T. We want to get into God more. (He began to cry uncontrollably.) I feel like I have no power anymore. I feel powerless, frustrated, you know, like there is no hope. I just don't know why.

C2. Mr. S., with all that's going on with you right now, I hear you, Mr. S. I can understand the anxiety, fears, and frustration you must be experiencing. And its all right to feel that way. It's all right to question, but right now we don't have any answers. I know this must be very painful for you to hear you will not walk again, to feel you are walking in unforgiveness, to feel powerless and hopeless. I hear you, and I share with you, Mr. S.

Pt3. What can I do Chaplain? I don't know what to do. (It was then I asked if he believed in God. He replied yes)

C4. To answer your question: as I stated before, Mr. S., I cannot provide all the answers, but I can share that we must rely on and have faith in God and believe

that He will provide the answers we need. On the other hand Mr.S., we all must be held accountable for our own actions, just as we must come to the realization there is a reason for everything. Let's look at the fact that God has kept you alive. There is hope right there. Where there is life, there is hope. Your hope and power lie within. As you begin to search within yourself, seek refuge in God. Begin by saying your prayers, and you will not only find answers, but you will find comfort and peace. It is then, my friend, when real healing begins to take place and answers will become clearer. The psalmist has said, "God is our refuge and strength, a very present help in time of trouble," Psalm 46 in the Old Testament. Your recovery, your healing also comes from the power within you, based on your will and desire. It's all going to be up to you. Ask yourself: What is my aim and what is my purpose? Try to forget all the things that have passed and press on, and go from there with an eye on a good future with God for you, your son and T. If you are not a member of any church, I would strongly suggest that you line yourself up with a Bible-believing church that will help foster your growth and commitment to yourself, your beliefs, and to God. You can be all that you want to be, Mr. S.

Pt4. Thank you, Chaplain G. Nobody has talked to us or tried to help this way before. I mean nobody. Thank you, and God bless you. Can T. pray with us this time? (At this point, I watched Mr. S. become almost childlike.)

C5. Of course. (At this point Mr. S. opened his Bible to Matt. 6:9 and very proudly read the Lord's Prayer. After each of us verbally gave thanks and confirmed

God's power through the Holy Spirit to heal and to save, we hugged and I departed with a promise to visit again. I also reminded him again of the Chapel service on Sunday morning.)

Sociological Concerns

Mr. S. is a 23-year old African-American male. He is a single parent. His son is one year old. He also has a fiancee, named T,. who is very attentive to him and seemingly takes very good care of their son.

Psychological Concerns

Mr. S. is a somewhat frightened, frustrated and anxious young man who is very much aware of his physical situation. He is frustrated because he cannot find the answers that I feel may seem right to him. He seemed close to his fiancee and almost like he depends on her (as if they are all they've got.) He spoke of his family in a nonchalant manner and did not discuss them. He may therefore, be estranged from his family. He seemed to be used to being in control and very powerful in his world. He admits to doing wrong and therefore feels he is being punished by God.

Theological Concerns

The spiritual issues that seemed to surface were issues of powerlessness and hopelessness, as indicated early on in our session together. He had a sense of powerlessness in regard to the fact that the doctors explained that he will not walk again.

In the sharing of my faith and confronting his issues of his faith, he was able to grasp and to hold on to the fact that God is able not only to heal, but to direct him in all areas of his life; that it is God who is keeping him alive, and as long as there is life, there is hope. He has begun to search for the hope and power that lies within him by seeking refuge in God through prayer.

From this experience, I again came face to face with the fact that first and foremost in ministering to others, it is not always the sharing of or the providing of a spiritual presence, but the sharing of ourselves and allowing others to share their innermost feelings and being open to receive them and their experiences in a nonjudgmental way. I felt a real sense of closeness as we shared in a compassionate, warm, and genuine manner, very much at ease, especially the ease with which Mr. S. began to trust me was certainly uplifting for me and as I began to teach them and apply God's word to their particular situation, allowed for freedom and a measure of lasting peace.

Pastoral Care Stance

The pastoral stance used in this particular case is pastoral care, pastoral support, and pastoral counseling. A ministry stance of compassion is dominant throughout as well as support in being able to listen and to share in concerns as well as offer what is felt to be timely support in counseling and even in the teaching. I felt "a man cannot go the way if he is not shown the way." I helped and supported his efforts to raise issues

and discover what he needed to do to help in his faith journey as his healing would and could only begin when he had the courage to face certain issues and to look deep inside himself to see what his aim and purpose for his life and the life of his son would be and how he could face life in the knowledge that in knowing God and developing a relationship with God, He will bring about healing. Not only that, but in counsel I had him to really see that in this life we must take responsibility and be accountable for our actions.

Having listened to Mr. S. as he opened some issues in confidence, I could not help but see and feel the Scripture as it became so alive to me as found in Matthew 16:26, "For what is a man profited if he shall gain the whole world and lose his own soul? Or what shall a man give in exchange for his soul?"

"Mr. T. A."

Visit with patient T. A	**Chaplain: G W**
Situation: Pastoral Care	**Time of Visit:**
Diagnosis: Gunshot Wound	**Date of Report: 6/21/97**

Diagnosis

Gunshot wound through abdomen, buttock and (L) hip. This patient was a high school dropout, unemployed, and just "hangs out." Lives with mother who keeps him going with food, clothes, and shelter.

The Visit

I knocked on the patient's door. He raised up to look, but said nothing.

C1: Good morning, Mr. A. I am G. W., chaplain on this floor. I routinely visit all the patients here.

Pt1: (Silence)

C2: Have you had contact with a chaplain before?

Pt2: No. What do you do?

C3: We are members of the health team of this hospital. We give spiritual support to everyone, including patients, families, staff, and friends. We offer prayer as well as give Bibles to those who request them. We are simply here for

you, loving, caring, and serving.

Pt3: No, I don't know about any of that.

C4: That's all right. I am here to support and talk to you. How are you this morning?

Pt4: I don't feel good. My stomach hurts. (I had read the chart prior to seeing him. Friends came in and gave him ice water, then brought Chinese food for him. He was not supposed to have any of this and was sick the previous night.)

C5: Do I see a box of Chinese food on your table?

Pt5: Yes.

C6: Did the doctor give you permission to eat this type of food?

Pt6: No, but my friend brought it to me.

C7: It might be a good idea for you to check with the nurses first before you eat food that your friend brings. I know they mean well, but you cannot afford not to cooperate with your medical treatment.

Pt7: I know that. (Angrily)

C8: You seem to be a little angry.

Pt8: If somebody shot you in your stomach and messed you up, forcing you to wear a brace on your leg, you would be angry too.

C9: Do you know who and why they shot you?

Pt9: No, no, no.

C10: How far did you go in school or have you finished high school?

Pt10: No, I dropped out in the 11th grade.

C11: My point is that it's all right for you to be angry about this happening to you, but

you don't have to dwell on it. Get with constructive ideas for yourself and your entire life. Make good plans for yourself. Live to the best of your ability. (By this time I had his attention and the patient was looking directly at me.) Are you interested in a few positive pointers?

Pt11: Yeah! What?

C12: Return to school. Get your G.E.D. Enroll in college. You have a good mind and you can do anything that you want to. Just think positively and make good plans for yourself. Think about it.

Two days later, the patient was discharged. However, after our first conversation he was always cordial and wanted to talk.

I have noticed that all of the young men who get shot are very angry. It is unfortunate that their lives are just being wasted for practically no real purpose. Follow-up is needed for those who return to the community. If they are shot in the stomach, it cannot be replaced.

My ministry to these young men is to get them to think and ask for help or counseling that is available to them. Not many have had any constructive family, friends, or anyone speak or encourage them. Their anger is an element of destruction.

"FRED"

"Fred," a white male, late 30s to mid 40s, came into the trauma room early one Saturday morning, perhaps around 5 or 6 a.m. He had driven himself in, after having been shot while in his car on Broad Street. He stated that he was driving down the road and someone attempted to car jack him, shooting him in the process. As he was new to the area, he proceeded to look for help, finally discovering the Blue H signs for a hospital. Despite the fact that the holes in his story were as numerous and large as those in Swiss cheese, he appeared sincere and honest. He admitted that he had a problem with cocaine addiction in the past, but that he was in recovery and had been for several months now. He had recently moved from Ohio, where all his family lived, and there was really no one in the Richmond area he wanted to contact. He was unemployed but on disability. He went to surgery and was later admitted to M9C step-down. On Saturday night, I returned to visit and learned that some of his family were coming in from Ohio on Sunday. We talked for a bit, and he showed himself to be quite intelligent and professed to have "my own type of spirituality." As it is pretty obvious to me that I would make a poor prison chaplain due to the fact that I tend to believe people when they tell me something, I was drawn to Fred and hoped that he would be successful in building a better life for himself here.

Imagine my surprise when, less than a year and perhaps only six months later, Fred came into the trauma room again, having sustained yet another gunshot wound.

This time, however, he asked me to call a girlfriend whom he had begun to date shortly after the previous injury. I did so, and spent a great deal of time with her during that night. This woman, who was about my own age, was very bright and employed in a helping profession. She knew of his drug history, but had believed that he was recovering. That night, however, he had gone out to get "a fix," despite his lack of money. Apparently the pusher was not disposed to be charitable. Fred's lady friend had come because she cared a lot and wanted to make sure he would be all right, but she had realized that this relationship was not healthy and she was only going to become more and more co-dependent if she didn't get out now. I supported her in her decision, partially because I remembered how easily I had been "charmed" and could identify with her. She supported Fred until she felt he was strong enough to know that it was over. I applauded her bravery.

As a Christian and a chaplain, I am called on to refrain from judging, yet at the same time I must be able to see and speak the truth, in love. Violence happens to people in every walk of life: one involved in drug abuse and gang violence; a family sitting on the front porch on a pleasant summer evening talking together; a young man working in a restaurant in the "nicer" part of town; a family of someone who owed big money to somebody; a nurse taking her dinner break; a radiology technician whose daughter had unfortunately become pregnant by the wrong father. None of these situations is really any more tragic than the others or any less so. Families and persons are still violated and all of us, whether we know the people involved or not, are bereft. People are born because God has a purpose for them, and when violence occurs, many times lives are

snuffed out without God having the opportunity to work. Though I do believe that God can and does "work all things together for good for those that love Him and are called according to His purpose" (Romans 8:28), yet I truly believe that God agonizes over the things His children do to one another.

In ministering to the patient and family confronted with violence, the chaplain's role varies as much as the incidents themselves do. The most obvious variation relates to whether the patient dies immediately, dies during or after surgery, dies after a prolonged stay in the hospital, lives with permanent disabilities, or returns to life as usual. When a patient dies either before arrival or shortly thereafter, the chaplain is usually faced with greeting a family who does not know that it is already bereft. I have found that, since chaplains cannot inform of death, it is preferable to ask someone to take the family to a conference room while I gather the appropriate physician and go in with them. I see this as both support for the physician, who has to perform the task that is probably the most hated of all the things he/she has to do, as well as providing a resource for enhanced communication between physician and family. Once the physician leaves the room, my pastoral care responsibilities come to the forefront. Providing condolences, the bereavement packet, tissues, the opportunity to view the body, support as they do so, and in many ways attempting to embody the love of Christ for these people at this time. Sometimes I have to take on the role of family advocate, sometimes the "gopher" who gathers the people that the family members want or need to see (i.e. police, Patient representatives, etc.), frequently educator of what one does when a family member dies.

One of the responsibilities that often falls on my shoulders, probably because I tend to handle it more diplomatically than many other staff members do, is that of "crowd control." Although I hate that expression, the concern is that there is limited space and other patients who also have a right to privacy and protection. This situation arises frequently at MCV and, actually I would rather handle it (with assistance) than leave it entirely in the hands of Security. There have been two incidents fairly recently that stand out in my mind where family members or friends of victims have been arrested in the ER driveway because they were purportedly acting violently. I cannot address whether these arrests were appropriate because I was inside the building and they took place outside; however, there have been innumerable times when angry family members were able to maintain control of themselves by virtue of being treated with respect and caring. One such incident occurred recently when a 17-year-old black male arrived with a gunshot wound to the chest. Although he was reported to have been talking at the scene, he began to be coded in transit and was pronounced dead shortly after arrival at MCV. We had a variety of friends in the waiting area, but we could not inform them of the death until immediate family arrived. Eventually, the young man's 19-year-old brother arrived. Unfortunately Richmond Police informed him and other family that the patient had died before the physician or I could meet them. Thus, after Registration interviewed him for patient information, I was finally able to bring him back to a Family Conference Room. He was angry at the situation in general, and at that point MCV had not done anything to help him with it at all. As I introduced myself, I asked if he would like to speak to the physician and he responded, abruptly and vehemently, "I want to see

my brother!" My response was easy --"Okay, let me see if he's ready. Can you sit in here for a second while I go check?" He complied. I went to the trauma room and ascertained that they were nearly ready. I went back and told him it would be about five more minutes and told him a little about what he would see. I also told him, apologetically, that, because of the nature of the death, the medical examiner would have to review the case, and to protect any evidence that might help solve the crime I had to ask him not to touch the body. He agreed to that. Shortly after, I was able to take him back, and he was careful not to touch the body. It was amazing to see how this affected him. Where my perception of his emotions until that point had been predominantly anger, when he saw his little brother lying on that gurney, lifeless, he began to weep, saying "My baby brother is dead." Bereavement entered the picture. Anger didn't leave, but it made room for something else. This brother remained respectful and polite to me throughout the evening and thanked me for all I had done when he left. All I had done was respect him, listen to him, and care about him.

Analysis

As an aside to this situation, I had a conversation with a VCU police officer later who stated that he believed we should never let families of crime victims view the body. I simply stated that I disagreed with him and that if it was ever proposed I would fight for a family's right to see their loved one. This was not a heated debate. I have no feelings of animosity towards him nor do I perceive any from him to me; we simply disagree. However, I will be glad to tell anyone that kindness, respect and empathy seem to me to

be much more effective in handling what can become volatile situations than do force, uniforms, arrests, and guns.

Another aspect of chaplaincy in situations of violence is the tendency for those of us who see these situations often to become jaded. One night about ten members of one family came in after having been shot in a drive-by as they sat on their front porch. Thank God, none of the injuries were life-threatening; in fact, most of them were treated and released. However, my first reaction as the family voiced their feelings of trauma was to think, "You don't know how blessed you are. I see people killed and maimed nearly every shift I work." Then I re-thought my reaction, trying to identify with how I would react if this was my family. They had every right to their feelings of violation, fear, anger and shock. I realized I was on the verge of becoming cynical and unempathetic. To love my neighbor as myself sometimes involves putting myself in their shoes.

One other issue we should remember as we think about ministry with victims of violence is that there are types of violence that never bring one to the hospital. A young woman came in one evening after being sexually assaulted. This was a particularly heinous event, as a knife was involved and treatment included surgery. The woman was in great pain during her time in the ER; however, it was apparent that she was also under the influence of either alcohol or drugs. When her family arrived, they gave a history of this woman's life on the street which included prostitution and drug abuse. The patient's mother made a startling and tragic statement when she said, "At least I know where she is tonight." Ministry with this family in the ER only began to scratch the surface.

Though there are similarities that one finds in incidents of violence, they remain as different as the people to whom they happen. Accordingly, I felt it might be easier to share some anecdotal evidence of theological principals in practice. If I were to summarize pastoral care with victims of violence, I would quote Christ in Matthew 10:16, Matthew 7:1, and of course, the second of the two "Great Commandments" Matthew 22:39: "See, I am sending you out like sheep into the midst of wolves; so be wise as serpents and innocent as doves. Do not judge, so that you may not be judged." And a second is like it: "You shall love your neighbor as yourself."

"CHARLES ISLAND"

Trauma Patient

The Case of Charles Island. This is a fictitious name that was assigned to this patient as a result of the type of injuries and the possibility of further endangerment to the patient, visitors, and staff of the hospital. This patient was referred to me by the night duty chaplain that listed in the margin of the log book, my name. As I followed up, there was no trace of this patient after leaving the emergency room. It was not known if he had survived or was discharged from the hospital. It seemed unlikely that discharge was a possibility because of the number of gunshots that he'd received. Through the patient information service, I was able to find the patient located in one of the ICU units. I visited Charles along with the regular duty chaplain for that floor. Upon entering the unit, we were directed to the bedside of an 18-year-old African-American male. The patient was hooked up to many I.V. lines with intravenous apparatus. He was also on a ventilator. Seated next to the patient's bed was a young African-American woman who was gently caressing his arms. The man had a very velvety smooth complexion and had very dark skin. He was not moving, did not seem to be flinching or have any type of movement except what appeared to be a normal breathing rate. His legs and arms were bandaged. The woman seated next to him identified herself as his fiancee.

C.W.: I am Cecelia Williams. I'm one of the chaplains. (And the other chaplain, PC introduced herself. I asked how she was doing and she said okay, but that she was very concerned about Charles because of the extent of his injuries. The medical staff told her that he was in an induced coma to prevent his suffering and also to prevent thrashing around and possibility excavating himself from the ventilator. I asked if she knew what had happened. The response was, yes, that she knew, that he had fallen at her front door. She said that she heard the gunshots and went to the door and saw him fall there. She did not see who had done the shooting; however, the EMS was called and he was brought into the hospital. This young lady also expressed concern about her three-year-old child who saw him lying there at the door, bleeding. He had also heard the gunshots and saw him removed in the ambulance. The child asked her if he was going to die. She said that they hoped not. She was also concerned that her door had been riddled with bullet holes, that this would be a constant reminder to the children of what had happened. I advised her that there were some support groups for children that allowed them to express their fear and concern through art and that I would bring her further information. We concluded the visit with exchange of information.)

I visited the next day and was told that Charles would be transferred. To my surprise, he was transferred to Main 9 Central, a medical/surgical floor. When I saw him, he was seated in a wheelchair, and they were arranging him in a new room. This seemed very quick for the amount of injuries that he had suffered. As it turns out, the injuries were to his legs and arms and only grazing the abdomen. Although he received eight bullet wounds, these turned out not to be life threatening; however, a great deal of

pain is associated with the type of injuries that he received. While the nurses were arranging him, I was asked to take the family to a waiting area and help to orientate them to the visiting arrangements for cases like his. It was important to reiterate to them the necessity to maintain the confidentiality about his location in the hospital and not to disclose his alias name. This was explained to the girlfriend, as well as the patient's father. When the fourteen-year-old brother appeared, I also rehearsed the same rules with him. The father assured me that only the six persons listed would be invited to visit. I visited this person the third time and was able to talk with him. The conversation focused on how he was feeling and his recovery. I decided to confront what I considered the real issue. I asked how did he feel when he realized that he had been shot. The patient paused a long time, seeming to contemplate my question. He finally began to talk and he said,

Pt1: Well, I have to say that I am real scared. I thought that I might die while we were waiting for the ambulance.

CW2: Were you conscious?

Pt2: Yes, I was at first, and then I don't remember what happened.

CW3: Do you remember who shot you?

Pt3.: Yes, I know who shot me.

CW4: Is there anything that you need to tell the police or anyone?

Pt4: No, I already talked to the police.

CW5: What do you think would make a difference in what's going to happen when you

are released?

Pt5: Well, I've been living a fast life.

CW6: What do you mean by a fast life?

Pt6: Well, you know, fast money and the kind of work that it takes to get money quickly.

CW7: Did you graduate from high school?

Pt7: No, I dropped out in the tenth grade and I was going to adult education school, but I found that I did not have enough time and I needed to work more.

CW8: It's good that you have recognized that your lifestyle has resulted in the injuries that you've received, and I'm wondering if you have had time to think about and re-evaluate that.

Pt8: Well, I've thought about it, and I think I'll try to go back to school.

CW9: Are there other thoughts that you have about it?

Pt9: Well, you know, I've never gone to church. I haven't done anything like that, but I'm very glad that God has taken care of my life and that I didn't get killed.

CW10: That's a wonderful awareness. I'm wondering if you feel that your girlfriend will be able to support you in that decision.

Pt10: Yes, she goes to church. I can go with her.

CW11: I'm glad to hear that. I certainly hope that looking on this experience, you will realize that there's a need for you to change your life and that no matter how quickly you get money, if it costs you your life, it won't do you any good. May I have a prayer with you before I go?

Dear loving God, we thank You for the gift of life. We thank You for Charles' life and that in Your mercy, You have seen fit to give him another opportunity. We pray, Oh God, as he thinks and reflects and is confronted with choices, that he will make choices that are better than he has in the past, that will allow him to lead a productive life. We recognize, Oh, Lord, that there are difficulties, and we pray that he will have the strength and the courage to grow and be healed from this situation and to find hope in new life. We pray for his girlfriend, who is here and for her children and for their parents that they will, working together, build a better life. Please hear our prayer. In Jesus Christ's name we pray. Amen.

I will come and check on you again and see you before you go home.

Analysis

Sociologically

He is an African-American male living with his mother who is separated from his father and part-time with his girlfriend who has who has two children. This young man is eighteen years of age. He is unemployed. When he was found he had $900 in cash in his pocket. He has been leading a lifestyle that is involved in criminal activity with both gambling and drugs.

Educationally

He is deficient and has no job skills at this time. His father is involved as well as a girlfriend who is older than he is and seems to acts like a big sister or mother toward him. He had a lot of symbols of support with many balloons and well wishes. He verbalized the need to make some changes in his life.

Psychologically

He seems depressed, and sometimes his affect is rather flat. He expressed fear of the possibility of death and gratitude for not dying from these events.

Theologically

He expresses a need for change, but there seems to be little enthusiasm for this. He had no early training and religious life as a child. He only has the example of the girlfriend whom he is able to relate to in a religious context. At times during the visits, he seemed somewhat indifferent to having a chaplain call on him and would have probably referred looking at TV. The farther away he was from the actual time of the injury, the less receptive he seemed to be with chaplain visits. It is my hope that this man will make progress, but he will need a lot of support from various systems in order to do that. His mother, during his time here in the hospital, created a verbally abusive scene with a nurse. Fortunately, they somehow worked through that conflict, and she was not asked to leave the hospital. The plan from the social worker and psychiatric liaison is that the mother will seek housing in a different neighborhood. From the psychiatric

liaison's point of view, no further treatment is necessary because he does not continue to have dreams or flashbacks.

"Mr. P."

Age:	**57**	**Chaplain R D**
Sex:	**Male**	**Diagnosis: Blunt Wound & Fracture**
Floor:	**M9C**	**Date of Report: March 27, 1997**

Background

I had just come from the hospital room of a gunshot victim. As I was walking down the hall, I heard Mr. P. moaning and groaning.

C1: Are you okay?

P1: Oh, Doc, Doc, I'm in a lot of pain. I'm in a lot of pain, Doc.

C2: I'm not a doctor. I'm Chaplain D. Do you need me to call the nurse?

P2: Could you, please? (I pushed the button to call the nurse. When she came, I spoke with her in the hall about his condition. She came in and helped prop Mr. P. up. The nurse left and came back a few minutes later with pain pills. She told me a little about his surgery, then she left. Mr. P. and I resumed our conversation.)

C3: So what happened?

P3: I was assaulted.

C4: You were assaulted? (The nurse came in and propped up his arm.) You said you were assaulted. What happened?

P4: I was in Community Pride cashing my check. There was another gentleman in the store with me. He followed me out of the store and started hitting and kicking me. He hit me on the arm with a crowbar and broke it in eight places. The bone was sticking out. He beat me in the face. He told me to give him my money. I threw it on the ground and ran.

C5: I'm surprised you had the strength to run.

P5: I was surprised, too. I ran home and called the ambulance and police.

C6: Are you angry about what happened to you?

P6: No, I'm just in pain.

C7: Did they catch the guy?

P7: No.

C8: Did it happen in plain daylight?

P8: Yeah, in plain daylight.

C9: Are you angry?

P9: I'm in too much pain to be angry. Ask me that after I've healed.

C10: Maybe we need to look at the reasons for your pain, so that you can help process some of these things as you heal. You need to heal physically and emotionally.

P10: I never thought about that. I do need to think about why I'm in here and what to do when I leave.

C11: You don't need to solve it all today. You do need to think about the assault and why you were assaulted. If you need to talk about it, I just want you to know I'm here for you. Do you have any family support?

P11: I have a brother that lives about an hour away and a girlfriend that comes by every other day.

C12: Do you want me to contact anyone for you?

P12: Could you contact my brother?

C13: I know you're tired. How do you feel now?

P13: I feel fine.

C14: Are you still in pain?

P14: No. They didn't have the IV in right at first, so the morphine was just going under my skin and not easing the pain.

C15: You look sleepy. I'm going to leave now. Do you mind if I pray with you before I go?

P15: No, I don't mind. I would appreciate it if you did.

C16: I prayed for him. I prayed that he would heal both physically and emotionally. I prayed that he would find peace.

Social Implications

Socially, the experience that Mr. P. suffered is reflective of the continuing downward spiral in which our society seems to be spinning. It's not enough that many of our senior citizens have to worry that their social security checks won't be enough to get them through the month, now they must worry that they can make it home without being mugged after cashing the check. Our senior citizens are no longer respected but preyed upon.

Psychological Implications

Psychologically, many of our senior citizens must feel isolated and fearful. Those who see the need to be cautious probably fare a little better than those who do not see the need and find themselves being taken advantage of.

Emotional Implications

It must be devastating to reach a point in life where you are unable to protect yourself, especially if you're a male, from a physical attack or a least move fast enough to escape the attack. The emotional wounds probably reach more deeply than the physical.

Spiritual Implications

To help him deal with his denial and help him see the need for healing of his person, his whole person. To help him see the grace of God even in this situation. To help him see that anger and fear are a natural part of the human experience, that they may not need to be acted on but embraced if healing is to take place.

injured. What is his name?

F2: XXXX

C3: And your name?

F3: XXXX

C4: Perhaps you would be more comfortable in one of our other waiting rooms. You will have more privacy. (I lead her to one of the family waiting rooms and she continues to cry. I can smell alcohol.) You must love him very much.

F4: (She nods and cries some more.)

C5: Can you tell me what happened?

F5: I was at my boyfriend's apartment, and we were just fooling around. He fell and hit himself on this art object he has (she describes the object.) Then this thing appeared which keeps getting bigger and there was blood. I got him into my car but his friend drove up after me and blocked my car and I had to get his key and move his car to get out. He was giving me directions. Turn left, turn right, etc., and I was crying, and he was bleeding.

C6: You must have had a difficult time seeing as well as not knowing the directions.

F6: Yes, he used to drive the shuttle bus so he knew where he was going.

C7: Will he need an operation?

F7: He probably will to stop the bleeding. (More crying.)

C8: Where are you from?

F8: Japan.

C9: Do you have any family here?

F9: No. (More crying.)

C10: Does Richard have any family here?

F10: No. They are somewhere in N.C. They are in the military and travel a lot.

C11: Let me go check and see how he is doing. (When I talk to the nurses and patient representative, they already have his name. When I tell them the girlfriend's version of what happened, the nurse makes a statement that she was performing hari– kari on him for leaving her to be with some other people. The patient is going to surgery to stop the bleeding. The VCU security guard has called the Richmond police. I ask if she can see him before he goes to surgery, and the nurse says that is up to him. I don't ask. I had not established any contact with the patient and asking him didn't seem appropriate.)

C12: He will be going to surgery to stop the bleeding and to find out the seriousness of the wound. (More crying. We talk about the instrument, which is a glass art object which she never liked, about her future in graphic art, their classes, etc.)

C13: Let me check and see if he has gone to surgery, and I will take you to the surgical waiting room. (The patient had been taken to surgery and the VCU guard is waiting for the police. They want me to leave her in the room until the police come.)

C14: He's been taken to surgery, but you might be more comfortable waiting here.

F11: You must have other people to see. You can leave. I'll be OK. (I leave and wait outside. The chief of the VCU police arrives and I ask him who has responsibility or has jurisdiction for the case. He tells me it's a dual

responsibility since they are VCU students but the crime was on city property. A Richmond city police officer arrives, hears the details, and leaves saying he will be back. I tell the patient rep that I am leaving and ask to be called if needed.)

Sociological Implication

Patient is a senior art student at VCU, majoring in film production. His girlfriend is also a senior, here alone, and is applying for a work visa. The couple was drinking and, either by accident or intention, the patient was stabbed in what appears to be a domestic dispute.

Psychological Implications

The patient was laughing, smiling, and varied his story, probably to protect his girlfriend. The girlfriend cried and sobbed throughout the visit and never changed her story. There is probably guilt on both sides regardless of the "truth." I feel the girlfriend sincerely cared for the patient and was genuinely concerned.

Spiritual Implications

This visit brings out the issues of guilt, the need for confession and honesty, forgiveness on the part of both, mercy, and the pervasive issues of violence and brokenness in our society. There also appears to be the attitude of guilty until proven innocent on the part of the staff.

Self-Evaluation

I felt very ambivalent about this visit. I had no problem with being with the girlfriend and providing support, but I did not want to be a part of the police confrontation. I did not feel that was my role nor did I feel it was my role to detain the girlfriend. I did not want to be identified as an adversary once I had established a helping relationship. At the same time, I felt she needed some support when the police did question her. I also felt I was being manipulated by the ER staff. I feel my role was supportive. I listened, and I was realistic regarding the patient's conditions.

Learning Issues

My major concerns are whether I should have asked the patient if he wished to see his girlfriend prior to his going to surgery and my role regarding the police investigation.

"David Jones"

The case of David Jones, (not his real name), a 35-year-old African-American male. He is handsome, tall, a well-built young man and very personable and inviting to talk with. I first visited him when he was a patient on Main 9 Central. I was referred to him by his nurse, who was taking care of him. That evening, upon entering the room, I asked if I could come in and talk for a while.

CW1: Hello, David, my name is Cecelia. I'm one of the chaplains here with the hospital. I'm wondering if you would mind talking for a while.

DJ1: Sure, come on in.

CW2: What brings you into the hospital?

DJ2: Well, you know, I got shot and I had a bad wound in my abdomen and in my shoulder, and I'm very grateful that it didn't hit any of the other vital organs or even my back.

CW3: David, do you mind telling me how it felt when you realized that you had been shot?

D.J3: Well, you know, I didn't realize it at first. When I heard the shots, I thought I saw my friend get hit, but I didn't think I got hit at first. Then I saw the blood on my arms and I saw it on my stomach, too, and at that moment when I saw the blood, I began to feel the pain, and I got real scared.

CW4: Is this the first time that anything like this has happened to you?

D.J4: Well, I was in the Gulf War, and I saw minor action, as far as being shot is concerned, and I had a very active lifestyle; but it's really about this experience that has really called my attention to let me know that I've got to change the way that I've done a lot of things that I've been sorry for, and actually, I've hurt people that I love.

CW5: Is there anyone in particular that you've hurt?

D.J5: Well, my mother and grandmother and my girlfriend; and I have a little boy. But I just want all of this to be behind me and to be able to get on with leading the kind of life that I'm supposed to lead. I was brought up in a Christian home and my parents, my grandmother, and everybody always prayed for me, and I just want to be a Christian again.

CW6: That's a good thing to want, and I certainly am willing to pray for that.

D.J6: Do you have a Bible?

CW7: Oh, yes, we can get a Bible, and I'll bring one here for you. I was wondering if it would be okay if we pray together now.

D.J7: Oh, yes, would you, please?

CW8: Dear loving God, (and he starts to pray with me and he repeats.) Thank You for this day and thank You for this life (he continues to repeat.) Lord, we bring David before You, asking, Oh, God, if You would do what only You can do and touch and heal him. We ask, Oh, Lord, that You would accept the repentance that he now makes for his sins and forgive him for the things that he has done, and

give him new hope that he might live for You.

D.J8: Thanks, Chaplain.

CW9: I'll be back and check on you.

Conference with Nurse After the Visit

Nurse: Chaplain, I'm really glad that you went to see him. You know, I know that guy. We were in the service together, and I kind of lost contact with him. I know that he got out of the service with a history about having some drug use, and actually, it was a questionable discharge. Some of the tests don't look so good that are coming back.

CW: What do you mean?

Nurse: Well, he may have something else going on, too.

CW.: You think he might be...?

Nurse: Yes, he's probably positive, but I hope not.

CW.: Okay, glad you're taking care of him. I hope that relationship will mean a lot to him.

Nurse: Yes, I like him. I hope he'll do okay and can get out of this.

CW.: Thanks, I'll be back.

Analysis

David is a man that seems to be optimistic and reflective. He is open and uses his personality to make friends easily. He comes from a background that has a stability that

taught him values as a young person. He has a history with the military but experienced addiction problems, as well as his current injury. He was willing to talk about what went on.

Sociologically

The African-American male is at high risk of endangerment for his life, especially with drug use in this community. He was employed and the unwed father of his son. He is connected with his family, that has provided motivation and incentive to want to make some changes in his life. The injury is an opportunity for him to reflect on his life and the choices that he made in the past.

Theologically

He understands what the Christian tradition is and believes that he needs to repent, confessing of sins, and he believes in the grace of God for salvation. This was expressed during the visit and in his indications for wanting prayer, as well as asking for a Bible. Theologically, it will take the grace of God and the power of the spirit of God, along with all of the will and other support that he will be able to gather to make the kind of life changes that are necessary.

"Terry Daniels"

This is a 23-year-old man who was shot three times on this occasion. This is the first meeting with this man. I had been recommended to visit him by one of the nurses. I introduced myself.

CW.: Hello Terry, I'm Chaplain Williams, one of the chaplains here at the hospital. Do you mind talking?

I noticed that he had nail polish on, and at first glance I wasn't sure if I was speaking with a male or a female. I quickly recognized him to be a man. He talked for a while and told me about getting shot this time. He said that he had a discussion with a "client," (Terry is a street prostitute), and his male client was disgruntled with the transaction. He unexpectedly was shot and left for dead, but he felt that it was miraculous that he was able to get up and run to the outreach ministry that's called Tree of Life. Medically, Terry has been proven to be paralyzed. This man talked very freely about his anger with the man who shot him and with his anger with his father, who had molested him many years before, and his anger with the person who had beat and mugged him on other occasions, as well as his anger with someone who had deliberately attempted to run over him.

Terry has a cocaine habit, alcohol habit, and other mental disorders. He was a

patient for more than seven weeks at the Medical College. The first visit was interrupted when his mother came in to visit. I stayed a while as they exchanged their greetings. She called him "John" and explained, after talking with him a while, emphasizing his name. She spoke directly to me and said, "he calls himself something else, but I always call him "John" because that's who he will always be to me." His mother is a middle-aged woman and looked older than her 52 years. Terry spent his early years living with his paternal grandmother, and, when he was fourteen, his mother regained custody of him. By that time, he had already dropped out of school and was dressing as a female and staying up all night and practicing prostitution. Daniel's overall basic character changed because of his circumstances. While he says that he believes that God has spared his life, he also thinks pleasurably about getting "high" and longing wishfully for the days when he was back on the streets or at least active enough to have sexual companionship with men. He remarked to me one day, as I walked with him on his walker to the smoking deck, that he does not know why God has made him like he is, but he still wishes that he could have a man again. His injuries have caused a colostomy and paralysis in his legs. At one point, he became very despondent and said that when he knew that he was going to be paralyzed, he considered suicide. No attempt at suicide was made, however. The more he practiced at rehabilitation, the more optimistic he became. The Richmond Times Dispatch and other newspapers carried his story. The total cost of his hospitalization at the Medical College will come to about $385,000.00. This does not complete all of his medical expenses, as he will need continued medical support for the rest of his life. He is a recipient of disability because of his mental illness. When Terry left the hospital, he

was placed in a subsidized apartment. The gunshot victims who come to MCV face a similar plight because of lack of education, lack of job skills, and serious physical limitations.

Analysis

Sociologically

Terry is a 23-year old Caucasian male. He is a victim of a gunshot wound. He has a long history of criminal activity that includes prostitution, drug addiction, and theft. He has served short-term periods of incarceration. His mother is close to him and continues to provide support, as well as one of his sisters. His other sister is detached. His father is in prison for child molestation. He was a victim of sexual assault by his father. He has experienced living in different homes as a child, with little stability and a lot of poverty.

Psychologically

He has been diagnosed as a manic depressive, drug abuser. He has severe mood swings. He moves from being dramatic and grandiose, to presenting himself as weak and helpless. He is confused about his sexual identity, believing himself to look like a female, therefore dressing like a female and experiencing the insults of his gender confusion. Those insults have included physical battery from people who sought sexual favors from him and later found out that he was a male.

Spiritually

He has been confronted with death many times. He believes that God has good intentions for him because he's still alive, and he has survived many incidences that could have taken his life. He has not made a thorough resolve to change his lifestyle, although he recognizes the need to do so. The change that he does agree to make is to eliminate cocaine from the things that he uses recreationally. He also declares that he will no longer be a "street walker," of course, his physical condition will prevent him from doing this. He, at times, was very demanding of the nursing staff and wanted things his way very quickly. His attitude proved to be helpful in convincing the physicians to recommend him for rehabilitation after they initially believed that it was hopeless to engage in any rehabilitation for him. He has some concept of God. That concept has not been shaped in any formal way, but he does have faith in himself and those who are his care providers.

"Mr. Strong"

First visit with Mr. Strong, (not his real name), a 42-year-old African-American male. Mr. Strong received two gunshot wounds to the back.

CW1: Good afternoon, Mr. Strong. My name is Cecelia Williams, and I am one of the chaplains here with the hospital. Do you mind talking with me for a while?

Pt1: No, come in. (We sit down and our conversation begins.)

CW2: Mr. Strong, do you mind talking about what happened?

Pt2: No, I got shot. I was coming from the 7-Eleven Store where I had bought a six-pack of beer. When I came out of the store, two young people on the corner stopped me and asked for a beer. I refused to give it to them and began to walk away. The young man who was about 17 said to the other one to get him his gun. And, I walked on. Surprisingly, I was shot twice.

CW3: What were your first thoughts when you were shot?

Pt3: I was surprised. I heard them say, Get the gun, but I didn't really think that they were going to shoot me.

CW4: How are you feeling about things now?

Pt4: Well, first I was afraid that I was not going to live and still don't know whether I'm going to be paralyzed.

CW5: Do you have family who live in town?

Pt5: Yes, I have a fiancee, and we are suppose to get married. We've been living together for about a year. I work at the mine; we're building a tunnel under the river.

CW6: So, you lead a very active life?

Pt6: Yes, and this injury is totally unexpected.

CW7: What are you feeling about this?

Pt7: Well, I wouldn't do anything to them, but I'm very angry with them. (He pulls his sheet back and shows me his colostomy bag.) The bullet went through my back and injured my intestines. It just really tore me up.

CW8: I'm sorry to hear that you're going through that now. (Pause)

Pt8: One of the men from work came by Sunday, and he's a minister. He prayed with me. Today is my girlfriend's birthday. I hope that she will get by here later.

CW9: Sounds like you have a very close relationship with her.

Pt9: Oh, yes, she means everything to me.

CW10: I'm glad that you have her because you'll need support during this time.

Pt10: Yeah, she's really a good woman, but I didn't want to be dependent on her like this.

CW11: I can understand that. Have the doctors talked to you about your condition?

Pt11: No, they haven't been in yet, but I want to know if I'm going to be able to walk. Right now, my legs just feel numb, and I can't move them.

CW12: You've been through a lot. I'm sure this was a shock and something that you do

not deserve. Is there anything that I can do to help you at this time?

Pt12: No, not at this time, but I appreciate your time.

CW13: I'll be back and see you again. May we have a word of prayer before I leave?

Prayer: Gracious Lord, we thank You for this day and for Mr. Strong, whose life You have protected. We thank You, Oh God, for his fiancee who supports him, and we pray for strength for both of them in these days of uncertainty, that You will be with him and guide and protect and give him the strength to face what is before him. I pray in Jesus' name. Amen.

Analysis

This 42-year-old African-American male is a casual victim (he did not have culpability in his victimization.) He works as a laborer. He has support in his girlfriend, but no extended family. He does have friends from work. Psychologically, he is appropriately angry about his injury. He does not seem to be looking for revenge. His self esteem seems to be high. He is loved and a loving person. He feels that his future is threatened because of the injuries. He does not seem to be ashamed of what has happened, nor by his colostomy bag, a symbol of pride. Theologically, he has a strong belief in God. He is a marginal church member, believes in prayer, and is hopeful for recovery.

Post Script

He was transferred to rehabilitation and his therapy has already started. It is still unknown whether or not he will be able to walk. He has an open attitude, which will be a tremendous asset towards recovery.

"Mr. B.C."

Situation: Pastoral Care **R. D.**

Diagnosis: Gunshot Wound **Date of Report: 3/30/97**

Background

Upon arriving to the trauma emergency room, I can hear the shouts and screams of medical personnel trying frantically to resuscitate BC. The doctor shouts, "Clear," as the nurse tries to jump start the patient's heart. As I walk in, I notice blood all over the floor. The young man is lying on the table with his chest wide open. The doctor is massaging the young man's heart with his hand. He doesn't know how many gunshot wounds there are, but the doctor is trying everything he can to revive BC. A cardiac specialist came down to see what he could do, but there was nothing he could do. I heard someone say, "Call 20:35," which would be listed as the time of death. When I initially saw the young man's chest open, I remember thinking to myself, he's not going to make it. Since I've been here, I have never seen anyone live after having had his chest cracked open in an effort to restart the heart. As I stood there, all I could think about was, How was I going to break the news to another black mother that her son was dead? I'm sick of telling black mothers that their sons have died, at the hands of another, of gunshot wounds. I'm sick to my stomach. I'm just sick of it. The family has arrived. It's about 9:30 or 10:00 p.m., and I'm being called to ER to meet with B.C.'s family, his mother

L.D. In my mind I'm thinking, Here I go again. Here I go again.

(C = Chaplain; LC=Mother; CG= Friend of victim)

C1: Ms. C, I'm Chaplain D. Let me find you a place to sit down.

LC1: I don't want to sit down. I want to go back there to see my son. (I didn't expect her angry tone.)

C2: Ms. C., I'll let you see your son as soon as I can get a doctor to come and talk to you to let you know the situation.

LC2: I want to see my son, then I'll talk to the doctor.

C3: That's not the way we do things here. We have to have a doctor or nurse clear it, so that I or someone else can escort you back to see the patient.

LC3: I can't believe this. I work with child protective services, and I've never had such trouble trying to get in to see a patient.

C4: I understand that ma'am, but you're not here today as a social worker. You're here as a family member. We have to extend to you the same care and courtesy that we do to all family members. Can I get you a seat?

LC4: Can you tell me something, Chaplain?

C5: What do you want to know?

LC5: Is he dead? (I paused for a second and looked her in the eyes.)

C6: Yes, he is, ma'am.

LC6: Why didn't they tell me this over the telephone? Why did they wait until I got here?

C7: That's not a healthy practice, ma'am. We have facilities here to help you deal with your reaction to hearing the news of the loss of a loved one. We can't help you at home.

LC7: Can I use the phone? I have to call some people.

C8: Sure, ma'am. Follow me. (There is a young man with LC.) I'm sorry, sir, I didn't get your name.

CG1: My name is C. G.

C9: What was your relationship to BC?

CG2: We were like this. (He crosses his fingers to demonstrate how close they were.)

C10: Were you all brothers? Were you cousins?

CG3: No. We were just best friends. I can't believe this happened to him. I was only in the house for five minutes, and he disappeared. I had no idea that he had gotten shot. I did hear nine gunshots though. I just can't believe this happened to him. Five minutes. I don't know if I was in the house that long. But now that I think about it there was a car in the alley, the street. (At that moment, the doctor approaches us. He spends some time talking with the family. Afterwards, I escort LC and CG in to view the body. A few minutes pass. The mother looks at me and speaks.)

LC6: Did you pray over the body?

C11: Yes, I did.

LC7: Good.

C12: Would you like for me to pray for you all now?

LC8: No, maybe later. I have some questions. I don't want his name in the paper. Who would I talk to, as it relates to keeping his name out of the paper?

C13: You need to talk with the patient representative.

LC9: Can I see the patient representative?

C14: Sure, let me go make a phone call. (I call the PR's office, but there's no answer.) I'm going to see if she's in her office.

LC10: May I come with you?

She spoke with the PR. The PR said she wouldn't release any names to the press, but LC would have to talk with the police to get them not to release. LC called the police and got into a long, and what appeared to be frustrating, conversation with detective W. She hung up the phone.

C15: How are things going?

LC11: He said he had to release the names in the first report. He's coming down to talk with me. We'll settle it then.

C16: Good. So he's coming.

I walked down stairs and sat and talked for a while. We walked and continued talking. LC decided she wanted to get in touch with her daughter to see if she would come to Richmond. LC said she didn't have any reason to stay here any longer. She was here to help her son become more independent by making him get a job and pay rent. She said she was ready to leave Richmond and go back home. She said, I just don't

know.

The detective showed up. I sat and listened for a while as he spoke with LC and CG. I was called to the nurses' desk. LifeNet wanted some information about the deceased. They wanted to know what I saw when I viewed the body. After talking with LifeNet, I went back to be with the family. I didn't want to interrupt the questioning, so I waited outside. I needed to get some information from LC for the nurses, so finally politely, I opened the door. The detective said he was finished, but he needed to talk with CG alone. LC walked out.

C17: Are you ok?

LC12: I ought to slap that ----- upside his head.

C18: Who, the detective?

LC13: No, CG.

C19: Why do you want to slap CG? (She began telling me how CG had come to her house asking whether or not she had seen BC because he had heard that he had been taken away in an ambulance. When she got the news, he came to the hospital with her in her car.)

LC14: CG and BC were not like this. (She crosses her fingers the way CG had done earlier.) Now I find out that he had come to my house and picked BC up to go some place with him. Not knowing what was going on, BC went. He ended up having to confront someone that CG had a confrontation with. The individual ended up shooting BC. CG not only witnessed the shooting, but also saw BC

taken away in an ambulance. BC had told me that CG was bad news because he beats up on his girlfriend and always go for bad. He had stopped hanging around with him as much as he used to do. BC got killed following behind CG's foolishness. CG messed his story up. That's why the detective was keeping him back there to question him some more. He was telling me one thing and got here and slipped and started telling another story.

C20: I'm sorry.

A little while later I walked her to her car. She picked up her little dog and began petting it. She asked me if I would like to pet the dog, so I did. She got in her car and left to go home. I later called to check on her. I asked her whether or not her daughter was coming. She said no. We talked for about 5 minutes. I told her that if there was anything I could do for her, she could give me a call.

Sociological Implications

From a sociological standpoint, the family, with mother as head-of-household, is more the norm than the exception. The scenario of what happened to BC is far too familiar an occurrence--young black males killing each other over seemingly insignificant matters. The plight of young black males in America is a symptom of a social problem that has reached epidemic proportions, too many Big I's and Little U's, too many men fathering children and turning their backs on them. As a result, too many of our young black males are growing up bitter and cold with too few black male role

models to lead them. When "Dad" is present in the home, often he is not training the young male to be a good man, but instead living his life for himself. In this situation, the child must take what he can get of his father's time and attention, and from this example, how to be a man. A sad indictment on our society is whether present or absent, very few men spend time fostering honor and dignity into their son, the kind of honor and dignity that surpasses the need to take another's life, the kind of honor that reminds the child that he represents not only himself when he is not home, but he represents his family, and a pride that he is so full of that he is empowered and liberated and shares it with others, who may need it more than he does in given situations. Where was BC's father? Who taught him how to be a man?

Psychological Implications

Young black males too often must feel their backs against the wall. When one is trapped, there are only two choices, kill or be killed. When Dad or some other male authority figure is present in the home, the child can, if nothing else, feel a sense of security in the knowledge that when danger arises, someone is with him. Unfortunately, in our society, Mom may not be able to instill that same sense of safety and security in the child as Dad can. These are basic needs that everyone, especially a child, should have met. Mom can tell the male child how to be a man, but too often the target is missed, when there is no tangible example to follow. TV, music videos, and movies present poor substitutes for the child to follow. They create a perceived notion that in order to be a man one must be willing to kill or be killed. And so we see one young

black male after another brought into the ER, the victims of violence. We should be teaching them the concept of fight or flight. Better to choose flight over fight when you can, because it increases your chances of seeing another tomorrow. Not that you are a punk for leaving and living, but wise because you have something to live for. And essentially that is what we need to give our young men, something to live for, something more meaningful than the money they have in their pocket, the shoes they have on their feet, the clothes they have on their backs, or the facade they present to their friends.

As for the Mother, she has lost the only son she has, and felt helpless to do anything to save her own child, no matter how hard she worked to save other children (as a CPS worker.) In the end, she lost her own child. I don't know everything that is going through her mind, but I do know what it feels like to feel powerless to do anything or to feel like you have worked hard for nothing. She lives in a time where the plague of violence seems to attach itself too often to the black male. She has been betrayed by her son's friend, by her son's choices, and she probably feels by the system and the world in which she lives in, that does very little about bringing resolution to the self-hate that is in epidemic proportions among our youth.

Spiritual Implications

How do we, as chaplains, instill in these young black males that this is not the way to live, when the survivors of the violence must return to face the same threats that put them in the hospital in the first place? We get through to the ones we can through prayer and counseling. We pray that the ones we can't get through to will someday see

the light. We get involved in the communities which we serve.

LC, I'm pretty sure she is living in her own personal hell right now, but the spiritual implication of this situation is real for her (as sometimes I feel they are only hypothetical for me.) Can she see God's grace in this? Can she resolve in her own heart not to hate CG or the man that shot her son, not feeling like she has wasted her time or life, but maintaining her purpose and meaning in life?

Personal Reflection

Having to own where I am as it relates to my role as the chaplain, leaves me no choice but to admit that I am sick and tired, frustrated, nauseated and almost moved to tears every time I am called to look at another African-American male lying on a stretcher dead. All I see is wasted potential. I am fed up with the mind-set of the people (my people) in the community in which he lives or hangs out at. I am sick of the oppressive system that has fostered this form of internalized anger which results in self-hate. I'm sick of people who have never had to live with or in the problem sitting in their offices thinking that they have solutions for the problem. I'm frustrated with those who escaped the jungle and turn a blind eye because they feel they have made it. I'm tired of the men and women who work on these patients and the comments they make to ease their anxiety, especially when the reality is that for many of them the closest they will get to a young black male is when they are lying up on that operating table. I'm mad at myself for sometimes being more concerned about my own ambitions and my own personal goals for my life and my career because I have tricked myself that I have to

accomplish x, y, and z before I am any help to BC's in the world. I'm just tired of all the useless and pointless dying and also feel helpless to change a thing.

Learning Goals:

a. What is God's grace in this? Help me find it.

b. What is my role in the life of the mother, grandmother, aunts, etc....?

(I know what theory and the text book says, but I don't feel it.)

c. Why do we hate ourselves so much?

d. What can I do?

e. The Fathers?

f. The System?

g. Why doesn't anyone seem to physically care?

"R. S."

Situation: Pastoral Care **Cecelia Williams, Chaplain**

Diagnosis: recovering from gunshot wounds

Background

R.S. is a thirty-one year old, unemployed, African-American father of two. He is single and has two sisters and a devoted mother. R. S. was shot in a domestic argument with his girlfriend, the mother of his children, when her boyfriend surprised R.S. by suddenly coming out of another room and shooting him in the chest. He continued firing, hitting him in the abdomen and stomach. R.S. ran for help. When he became too weak, he stopped on the porch of a nearby neighbor, and an unidentified person called for help. At that point, R.S. lost consciousness. The injuries were very extensive. His liver was slashed, and his kidneys were injured. The early reports on his prognosis were very grave. His mother and sister called their pastor, the Reverend Dr. James McCray, to come to the hospital. Rev. McCray visited with the family and patient. Prayer was offered for the patient's healing. After four weeks, the doctors informed the family that no progress was being made, and recommended that life support be discontinued. The family declined that recommendation, and clung to their hope that R.S. would survive.

The family called Pastor McCray, who returned to the hospital, and prayer was continued with members of the church, family and friends. After forty-nine days of

being comatose, after a night during which the doctors did not believe he would survive, R.S. regained consciousness and began to heal. The turn of events amazed the medical team, and they quickly responded by moving him into rehabilitation and other treatment protocols to fit his situation. Over the course of the hospitalization, his kidneys had shut down, causing poisons throughout his body and the loss of the digits on his left hand. He had more than four surgeries and spent a total of eighty-nine days in the hospital.

This interview begins with Dr. McCray reminding R.S. to be thankful to God for his recovery to this point. He has made significant progress, although the doctors expect that it will take another eighteen months before he experiences a full recovery. The interview took place in June 1998. We entered the family home on the south side of Richmond and sat in a very neat, pleasant living room. The television was on, and I asked R.S. if he would mind turning it off. He turned it down, and the interview proceeded.

Interview

CW: Would you please describe what happened to you when you received your injury?

RS: I was in an argument with my girlfriend, and her boyfriend suddenly came from another room and shot me in the chest.

CW: How did you respond?

RS: I shouted, "You shot me, you shot me," and I held my chest. As I started to turn, he shot me again in the abdomen and stomach. At this point, I ran from

the house as far as I could. When I found myself getting weak, I stopped to rest on a neighbor's porch and lost consciousness. Someone, whom I do not know, called 911 for help. All that time I was in the hospital, my family was there with me, and, for a long time, I did not believe that I would get out of the hospital alive. My mother and sister kept praying for me and visiting. My family was a tremendous support for me during this time.

CW: Do you remember what you were thinking or feeling at the time of your injury or while you were in the hospital?

RS: No, I just ran, and when I got to the hospital, I don't remember anything until I woke up.

CW: So, for all the time you were in the coma you don't remember anything that was going on?

RS: No.

CW: How has it been for you since your recovery has begun?

RS: Well, it's been really very difficult. I had a lot of surgeries which have made major changes in my life. As you can see, I lost part of my hand. That was due to my kidneys. They had me on dialysis, and my kidneys continued to fail, so this will never be right again.

CW: I was wondering. What are your thoughts about the person who shot you?

RS: Well, I know who did it. It was my girlfriend's boyfriend. That's the mother of my children. I know who it was, but I decided not to even press charges, because . . . I don't know. I just want it all to be over.

CW: Did you feel any resentment?

RS: Oh, yeah. I felt a lot of resentment, and I was angry, but I just felt that the best thing was to just let it go and just concentrate on getting well.

CW: That sounds like a very challenging thing to do.

RS: Yes, it has been. But, the worst part was, not just getting shot, but my girlfriend took the children and ran, because she didn't know what was going to happen, and I could have held them up on murder charges. She took my eight-year-old daughter and my four-year-old son, and she knows how much I love them. She was gone, hiding, for three months. But, she's returned now and I've been able to see my children.

CW: What are the doctors telling you about what they expect in your recovery?

RS: Well, I'm a lot better, but they still say it will probably take eighteen months before I'm able to go back to work.

CW: What kind of work did you do?

RS: I did labor work. I worked unloading trucks and so forth, like that.

CW: Kind of hard work.

RS: Yeah, real hard work.

CW: I was wondering if you have thought back on the experience very much since that time.

RS: Yes, all the time. I never get a good night's sleep. Every night I dream about it or think about it all night long, over and over and over.

CW: Reliving that must take a lot out of you.

RS: Well, sometimes, but I just can't get it out of my mind.

CW: Were you able to talk about this with anyone while you were in the hospital?

RS: Well, yeah, I talked to some people.

CW: Did you see a chaplain while you were there?

RS: Yes, I saw several chaplains on the different floors that I was on. I was on many different floors in the hospital. You see, I was there for eighty-nine days.

CW: I think it might help if you could get some help in getting over the trauma of this event and allowing it to come to some resolution. I'm wondering what it is that you want in the future.

RS: I was thinking about maybe going to school or something like that. Right now, I really don't know what I want.

CW: Has this even made a difference in your spiritual life?

RS: Yes, somewhat.

CW: How has it been?

RS: Well, every morning when I wake up, I thank God for being alive. Because, for a long time I didn't think that I would get out of the hospital.

CW: So, now that you are alive, what is it you see in the way your life will go? Has church been a part of your life?

RS: Well, no, not really. Occasionally I would go whenever I felt like it with my mother and sister, but I really was not a member of any church.

CW: I want you to know that I am sorry for what you have been through, and I do

hope this experience will help you to come to a deeper understanding of how God has been with you and an appreciation for that.

RS: Oh yeah, I do appreciate it.

Pastor: We're hoping to see you in our church. We welcome you to our eight o'clock service. It's a rather casual service, and you can come just as you are. If you need a ride, we'll be glad to come and pick you up and bring you to church.

CW: Have you spent any time in any groups talking about what happened to you?

RS: No, I haven't met with anyone.

CW: Would you be willing to do that?

RS: Yeah, I think I'd like that.

CW: Okay, I will be in touch with you, and, hopefully, we can get you connected with one of the groups that will be of some help to you. I appreciate your talking with me and sharing your story. Thank you.

The interview was closed with Dr. McCray leading us in a prayer for R.S.'s healing to this point. Encouragement is offered, and both his sister and his mother spontaneously join in by talking about and celebrating what their experience was like, and praising God for R.S.'s recovery.

"B.D."

Chaplain: Amelia B. Cannon **Date: July 19, 1997**

CPE at MCV/VCU

ENTRANCE

B. D. was admitted to MCV Emergency Room on June 16, 1997 at 12:09 a.m. with a gunshot wound to the groin area, reportedly self-inflicted. He is a 19-year-old black male. He was brought to the hospital by three or four people who said they found him in the apartment building of one of the girls.

I went out to the waiting room where the "friends" were about to leave. I believe a police officer was behind me, but we had not talked at this point. There is a tall boy with a gold tooth who has been drinking, a pregnant girl who is a sister to one of the boys, a small, masculine girl who looks to be high, and another boy, short, whose eyes are watery and he is unsteady. They are quiet, but mumble to each other.

A.1. *Hello, I'm Amelia, one of the chaplains here at MCV. Can you tell me his name?*

They look at me and at each other with blank looks on their faces. I ask if they are the ones who just brought a man in. They mumble something to each other and to me. They did not know his name. I ask for their names but they do not give them.

A.2. *Does anyone know who he is?*

-- He got ID.

A.3. *Who shot him? Where was he? Does anyone know his address?*

-- We just found him in the hall of her house.

-- What's his name?

-- He got her pregnant.

-- Antonio, his name is Antonio. What's Antonio's name?

-- His name is Bobbie.

-- I don't know him.

-- We were just coming in and he was in the hall.

The police officer was also going to ask some questions but was waiting for me to ask. They were standing in the door in a continual state of leaving.

A.4. *Could you tell me his mother's name and number?*

-- Her name is Boo-Boo.

-- What's Boo-Boo's name?

-- She's my cousin.

I take the number and try to call her. No answer. They talk among themselves and one of them tries to call her. They actually walk out the door this time. I leave to go back in the ER and the police officer is standing there. I look at him and say. . .

A.4. *I have heard about this all my life, I have seen it on TV, and have read about it, but this is the first time I have ever experienced it. No one knows anything. How amazing! He says yes, that it is almost always this way.* I say, *It's a wonder any crime gets solved* and go back into the ER.

Social

What kind of community do these people live in where they protect the perpetrator, refuse cooperation and are so non-communicative? I am amazed, but reality has just hit. This is an obvious difference in an emergency response and situational assessment than what I am used to. Their reaction, while self-preserving, is also perpetuating the cycle. I was quite astounded that the one who was pregnant by the boy might not know his name, but would bring him into the ER. I am amazed at the obvious lying, and by the blank look in each of their faces. I am not the one to question them. I should have had a black face, but I doubt that it would have made a difference at this point in their lives or in the life of B.D.

While the tall boy seemed to be in charge, they seemed to be like jellyfish in the ocean, wavering without anchor or decision or plan.

Psychological

They are denying their own existence by denying the life, identity, and description of their friend. This has been internalized all their lives. They are "we." I am not going to get anything from them. I am "the other."

Personal Assessment

What a great learning experience. This was such a shock. While I understand and know the cause of the apathy and un-cooperativeness, it still shocks me. I feel I was watched by the officer to see if I would get any more information. I did not feel I was

effective but I'm not sure anyone would have been, black, white, or purple. This is way too ingrained. Nor do I think standing in the doorway was the appropriate place to take information, but I felt that was their protection.

Spiritual Implications

Luke 8:10 "To you it has been given to know the secrets of the kingdom of God; but to others I speak in parables."

WAITING - July 19, 1997

B.D. was in the ER for about 30 minutes, to the best of my recollection. He was then taken to OR where he coded on the elevator. His chest was opened and the doctors proceeded to work on him. This is around 1:00 or 1:30 am.

Throughout the night, friends of B.D. come in and out. They are in the surgical waiting room. Chaplains M and D are present and the only time that stands out distinctly is when Chaplain M, D, and I are standing away from the people and M is filling me in on who is here and what is happening. D reports to me that M held back to let me take the lead with this family.

M tells me the mother is here. I go over and introduce myself to her, saying all the usual things. She is under the influence. The brother had come in downstairs and at some time was part of the group who brought him in. He was obviously under the influence and was somewhat hostile and jerking around.

None of the people in this group are comforting each other or are even sitting

with each other. I talk to each of them and touch most of them in some comforting manner.

I continue to check on them during the night. Several come and go, in various stages of being under the influence. I mainly remember the brother, mother, pregnant girl, and a short older woman, and the masculine girl. They seemed to be the regulars.

It is now 7:00 a.m. the next morning and various members of the group are in the waiting room for the burn unit. I don't remember how they got there. Here are the players:

> Four or five women are around 40 who are the sisters of Boo-Boo, the mother,
> Five or six teenage to young adult boys who are the sons of the mothers,
> Five or six teenage girls, two are pregnant, some are girlfriends, some are cousins,
> F, the mother's boyfriend, the tallest, calmest of the lot,
> The aunt of the pregnant girl,
> The aunt of B.D. who has been sending blood from the blood bank but didn't know it was her nephew,
> A young boy of eight or 10, a baby of two or three and another child.

In all, there are about 20 people, some are a little hostile, some are under the influence, most are calm, some are crying. There is no one at the desk, in the hall or even in most of the rooms. It is very unpopulated and I am feeling somewhat overwhelmed. B. D. is spread-eagled, open-chested and people are working on him. I don't want anyone to go back there, he is at the far end of the hall, through two sets of double doors.

Chaplains M. and D. check on me periodically. At some point, I call D to call for some security.

A.5. *D, this is Amelia, do you think you could call for some security to come down here? There are bunches of people in various stages of intoxication and feelings and I just don't feel comfortable.*

D: *Okay, I'll take care of it.*

Minutes later, I look up and see two policemen through the double doors. Since all the people in the room are facing inward, I don't think they have seen them. I didn't think too much about it and it did not occur to me that this was the security that I had called for. I was expecting one burgundy-jacketed guard. At some point, I am out in the hall and see a Jewish looking man in a coat and tie looking at the doorknobs in the hall. I ask if I can help him. He says no. I am still not getting it. I go into the office and see four uniformed policemen, three or more burgundy coats and three tall men in suits and ties.

By this time, I am sensing the discomfort of the mothers and see some shifting eyes from sisters to children. I go out in the hall where there are the men in suits and ties. One of the men is Paul Barr from the Patient Reps office. He introduces me to this tall, handsome light-skinned black man who is the head of security. They talk to me about B. D. being a gun shot victim, how someone might try to get him in the hospital and how we need to limit visitors. They ask me to get B.D.'s mother and someone who is level headed.

They are explaining things perfectly, logically and I think this means that B. D. is better and that he needs some protection. I still don't get that this is my phone call. When I go back into the waiting room, I go to the aunt from the blood bank to ask who is

the most level headed of the sisters. She names Mrs. J. I get B.D.'s mother and her sister, Mrs. J. We go into the office and they proceed to explain things to the women. Although I would have considered this very intimidating, the women were calm and listening. They discuss who should be on the list, decide the brother should not be and give the men some names. After all of this conversation, I go back into the waiting room and try to explain that this is going to take some time, that visitors are going to be limited, etc., etc., and that they need to get some juice or a drink and walk around.

As they leave to go to the cafeteria or wherever, the two suits rush on the elevator with them. Chaplain D and I look at each other and say, "That was subtle." If there was any doubt by the family as to why the extra security was there, there is no doubt now. I don't know at this point if I am totally aware that these people are all up here on my account or not. I remember saying to the suits that they handled something well, what it was I now don't remember but I feel that I probably didn't have a clue at that time as to what was going on.

Sociological Implications

There are many. I was unaware of the reputation of the security vs. black situation at MCV. In my life, police and security have been helpful, friendly, friends, and there has been no life-threatening situation. I wanted ONE security guard to keep family from going back to the patient. Perhaps another chaplain was all I needed.

Now that I have a history of this story, I know that many of the people sitting in that room actually knew what had happened that night. They also did not know, nor

acknowledge each other. The pregnant girl was referred to as "his baby's mama," "he got her pregnant," but as "his girlfriend" when introduced to the black chaplain, R.

I am clearly clueless as to the family dynamics and don't ask many questions to clarify the situation. When I do, so much is mumbled that I hesitate to ask for repetition upon fear of appearing rude.

I fear that the brother is going to do something to get even or shoot someone. This mother can't take another blow like this. The hostility of the young men, in general and some toward me, is the first time I have seen this in Richmond. That is all I have seen in Alabama, but not here.

Psychological Implications

They are in a scary place, that has a history of being hostile to them and bringing death. They have no advocate that they recognize and do not know each other to be friend or foe. Since many of them are or have been under the influence, their own senses could be distorted.

I am tired, clueless, and out of my comfort zone. There are too many people and I did need help. I trust the hospital to do the right thing but have seen them pumping stuff through this child and I considered it useless. My role is unclear to me.

AFTERMATH - July 26, 1997

It is after B.D.'s surgery, the nurses and doctors have cleaned him up and have covered him up. I take the mother, his aunt, the girlfriend, and her aunt back to see him.

happened downstairs, I say. . .

ABC: *I want to fix it. Let me go talk to the patient rep guy and get this straightened out.*

M: *Nope, your shift is over and you need to turn this over to the floor chaplain who is an RR.*

ABC: *But they already met R. Why can't I go straighten this out?*

M: *Your job is finished and now you need to turn it over.*

What I feel. . .

Now I am really frustrated and mad. I feel that the "boys" will work this out. I really hadn't thought about it being a male/female thing until my supervisor said something to me.

I am tired, overwhelmed, and confused. I also feel I have been disrespected among my peers and I hope I was not disrespected to the family in a "just us black folk" manner.

I feel I have stepped in it and can't get it off my shoes.

I feel that many people weren't where they were supposed to be or doing what they were supposed to be doing and I am taking a fall for that. That could be paranoia.

I feel that I have been labeled racist and/or prejudiced and/or clueless and that makes me very angry and frustrated.

There is more feeling but I can't label it. Like someone is lying or cheating.

What I learned . . .

I learned that the relationship between security and blacks is not good. Nor does it seem that an effort has been made to work on that by directly communicating with those who could call them. This was NOT a part of our lecture on security from the department. It is an issue, acknowledge it and work on it. This would be helpful in a briefing to discuss this positively.

I learned that it's okay for blacks to make stereotypical, unflattering comments about each other and the race but not for whites to do so. What a crock. "This is just how we black folks grieve" is stereotypical, racist and not true.

I learned that there is a racial barrier within the pastoral care department. While things are rocking along it does not display itself, but when there is a racial issue, the lines are divided along race that will keep the problem current.

I learned that I am basically a clueless person. Robert Young called me naive in my interview. That is not a word that I would have associated with myself throughout my past nor in my present. However, in this case it certainly applies. I haven't decided if that is a bad thing yet or not.

I learned that I do not call for help when I need it. I look back on my life and see that calling for help is not something I have ever done. I learned at a very early age that I will have to take care of myself. My cluelessness/naivete could be part of the protection against a need to call for help. I hope I get over this.

VISITATION

I try to visit B.D. every day that I work. My visits have usually been short to about five or ten minutes at the most. Several visits stand out to me: when his eyes opened, when the swelling went down, when he could talk, when he said he knew me from a long time ago. For many of the first visits where he was conscious, he looked at the TV for most of the time. Now he looks at me. Most of the time the visits go like this:

A1: *Hey, B.D., how are you doing today?*

B1: (quietly and softly) *Fine.*

A2: *You look fine. Do you hurt anywhere?*

B2: *No.*

A3: *How's your leg? Have you moved it anymore?*

B3: *No.* (we might talk about the feeling in his leg here)

A4: *You know it's going to take a while don't you? You just keep working on it. Are you bored?*

B4: *Yes. I'm ready to get outta here.*

A5: *I know you are. It's going to be a while but you have really made some great progress. Has your mama been here?*

B5: *Not today.*

A6: *Well it's too early for her still. Can I get you anything?*

He usually asks me to get the nurse or get a pillow or something. I always tell

him when I'll be back. Sometimes we talk about food, his digestive tract, his baby's mama, etc. As I type this up, I realize I haven't heard his story at all.

I have asked him why he thinks he is still alive. He said it wasn't his time to go. I asked him what will he do with his second chance and he said he would go back to school. These seem like empty answers to me.

I am clearly not relating to this man. As much as I see him and am with him, I should know his whole life story. He only answers in monosyllabic words and I have not begun to enter his world. I feel that I am the only face who does not pick and prod him with instruments, however, I do it with words.

Sociological Implication

As a 19-year-old, black, male, victim of violence comes in contact with a 43-year-old, white, female, student chaplain, the differences are obvious. What is not obvious are the ways these two can relate. I believe that the persona that B.D. is in the outside world is not that of what he is in the hospital. That persona I have not discovered. I have been comfortable with the healer/patient, mother/child, and visitor/visited role. However, B.D. already has these people in these roles who are real and who are already known to him. If I represent God's love and/or presence to him, it is in my coming, not my conversation. Now that coming draws to a close and I feel incomplete.

Psychological Implications

Here I will speak for myself. This story has been the ongoing event that represents my chaplaincy. My strengths are consistency and presence. My weaknesses are engaging the patient and letting God do the work. I still want this event to be fixed, this life to be whole, and the relationship of B. D. to the world not to be violent.

B.D. represents the unknown to me. The unknown family dynamics that I cannot understand, recognize, or identify with. The unknown life of violence, disrespect, victimization and death that are not part of my immediate world but is part of the world around me. He represents that unknown area of me where prejudice still lurks and in all its forms, classism, racism, sexism, ageism, middle Americanism. He made me taste the other life.

Theological Implications

The treatment of B.D. on the night he was brought in was an invasive one for which I was unprepared. I questioned the reason for keeping him alive, for using him as a learning instrument. I wanted them to stop working on him and to let him die. How pompous. What a miracle he has become. What a strength to survive this man must have. What an acknowledgment of the power of medicine and healing he is.

What God has in mind for B.D. is a mystery that I may never know. I like to think that B.D. will know but I cannot be sure of that. I like to think that B. D. will turn his life around and become a contributing member of society. I'd be glad if he would just raise his child. The dream of a society where everyone works, is educated, is needed, is

not a dream that I am prepared to give up.

What my role is in improving it I do not know. But being aware that there is a difference in how people live and why people live and in how they are treated and how they treat others is just a first step. This CPE has shown me those differences.

"XJ"

Introduction

I am visiting on the floor to orient new students at the beginning of a CPE Extern unit. I took two students with me into the nursing station to meet the nurses and to discuss the patients with me. Nurse J quickly told me that I needed to see XJ. She had been with him the night before when he was assigned to her, but refused to take him again tonight. When I asked why, she responded that he had "dogged" her so badly last night that she couldn't stand to be around him today.

XJ was recently assigned to Main-9-Central after being in an ICU unit for ten days. He is single, but the father of one daughter. He is close to his mother and other siblings in his family. The conversation with XJ was a surprise. Considering the account that Nurse J had given, it was surprising that when I walked in, this man quickly began to talk. He wanted to know who we were after introductions, and he expressed his gratitude for our coming, because he wanted to tell his story. He related that, as he was being treated in the ER, and further on up to the OR, throughout the ordeal, he was coached by a spirit that he calls God. That constantly he was told that he was going to be okay, and to just hold on. When he questioned this being about why he was going to be saved, he was told that he had done many things wrong, but that there was one thing that he had done right. That one thing was to care for his young daughter. And, because of that, he believed that God was sparing his life. He did not know what further things God would

require of him, but one thing he did know is that God was with him through the ordeal. As we further explored it, XJ said that he would like the opportunity to tell his story and share it with others; that he believes, although he has done these bad things in his life, this is an opportunity for change, and he looks forward to change and a good life.

The other chaplains who were with me offer him support and prayer is offered.

The Prayer

Gracious, loving God, we come before you this evening, thanking you that in your own divine wisdom and mercy you have seen fit to stand with XJ. That you have stood with him throughout the crises of his treatment and bring him now to this present time. We pray, O God, that you would look upon him with love and mercy, and that in his days of being here that he will be able to reflect upon his life and to understand those things which are for his good and those things which are not. Help him, O Lord, to make those decisions in ways that will be pleasing to you. We thank you again for the opportunity of life, that it may be valued and that he may begin now to have this as a turning-point in his life, to live for you. Please hear our prayer. In Jesus name, we pray. Amen.

Psychological

XJ has experienced a trauma resulting from gunshot injuries. His attitude has been aggressive with the nurse and, with the chaplains, one of gratitude and appreciation for life. He seems to have a high level of self-esteem. He is articulate. He is a good-looking person. His attitude about himself is reflective. He is admitting that he has

been involved in activities that have been destructive. He is a distributor of narcotics, as well as a user of these illicit drugs. The caution that is raised for myself is how much is to be believed. There is an incongruency between the spiritual event that he describes at the initial point of his injury and his behavior with the nursing staff. That incongruency raises the question and my own speculation of, is this story to be believed? It felt believable, but I'm wondering if there isn't some level of manipulation. Does this individual have a manipulative personality? Is he, somehow, identifying with the chaplain and using the spiritual experience, not for a life change, but to build a relationship with the chaplain? These are issues of concern.

Spiritual

The presence of God is remembered in this man at the point of his distress. When he is feeling that his life is most threatened, he is aware that God is there. This case raises the issue of grace. He is not able, in his recollection, to remember anything that would cause a God to come to his rescue. The only thing that he remembers, as witnessed in his life, is his relationship with his infant child. (The child is approximately three years old.) This suggests that God does shine on the just as well as the unjust, and that the presence of God and the activity of God are sovereign to God alone. God decides who will be saved, and it is not out of our merit, but the unmerited grace of God.

Sociological

This man fits the profile of many African-American males, between the ages of 15 and 30, who are involved in a lifestyle of criminal activity that results in gunshot wounds. The cost is astronomical to the institution. He is unemployed and uninsured. The financial cost of the care will be borne by others: the hospital, the state, and the federal government will all subsidize the cost of his hospitalization. The effects upon the community are an additional loss. He is lost for the possibility of employment for at least eight to twelve months. He is lost as the potential he could offer as a productive member of society. If change is a reality, treatment for his addiction would need to happen. He is articulate and educated beyond high school. He has strong family connections with his mother and other siblings. There is no mention of a father in this case.

"Mr. L"

Patient: **Mr. L, single male, age 50**

Diagnosis: **Colostomy take-down**

Chaplain: **Grace Williams**

This patient came to my attention during my regular rounds of Main-9-Central (Surgical Step-Down) on July 7, 1997. He was not very talkative, because upon arrival in the hospital, he really was not well. He was operated on July 9, 1997, and has been a different person altogether.

According to the patient, he was shot and robbed in Baltimore, Maryland in 1995. He was robbed, beaten and shot eight times. The medical care at that time was at the University of Maryland Hospital. He wanted the colostomy take-down in Maryland, but was never admitted for the repair. It is documented that the hospital would not readmit him for the repair.

Mr. L implied that he knew his assailant, and believes that is why he was shot so many times; four times in the stomach and four times in the back.

(C = Chaplain; P = patient)

C1: Good morning, Mr. L, I am the chaplain on the floor; allow me to introduce myself.

P1: Good morning. Thank you for coming to visit me.

C2: How are you this morning?

P2: Not very well, and now I have a plan for surgery, but the doctor explained not to expect much. In fact, I may not be any better off.

C3: I understand why you are not feeling too good. The message that you got is depressing.

P3: Thank you for understanding. I was hoping to get back to normal. You know, I have worked and supported myself, with the colostomy bag. Now, I may not survive the surgery.

C4: It is difficult, but we have to think positive. Would you like for us to pray about this matter?

P4: Yes, chaplain. Please pray with me.

[prayer]

P5: Thank you for a fervent prayer.

C5: Your faith will see you through. For some reason, I know that you have faith.

P6: Yes, chaplain. I have faith. You know, my sister insisted that I leave Baltimore about a year ago. Then, after I moved here, she took me to church with her. After several months, I accepted Jesus in my life, and I know that he is going to take me through this trial.

C6: Your sister had a plan, I believe, that is a blessing for you.

P7: I believe that she did, for me, and I am thankful.

C7: You have a good evening, and I will keep you in my prayers.

July 10, 1997 -- Patient's surgery date. Due to the fact that I was in a seminar, I did not get to see him immediately.

July 14, 1997

C8: How is Mr. L today?

P8: Chaplain, I am very well, and so happy to see you today. You know that I was in surgery for about seven hours. When I really came to myself, I called my sister and she didn't believe it was me. She cried for joy.

C9: I am happy, too. Remember that I told you that you had the faith.

P9: There is no doubt in my mind. I believe in the healing powers of Jesus. Please pray for me right now and let us thank God for this blessing of me getting rid of the bags.

C10: Will you pray this time?

P10: Chaplain, you pray for me, because I know that you have my interest at heart. Because I will be going home, and I will not have you around, please pray for me. [prayer of thanksgiving]

P11: Chaplain, I am grateful to you. Before you go, I want to tell you that the assailant that shot me, he was on parole, so he went back to prison for a long time. He robbed and killed before.

C11: Mr. L, you continue to win battles. You are blessed. When you are discharged, take care of yourself, and pray also to hold on to your faith. I will keep you in my prayers.

P12: Chaplain, I promise. Thank you for coming into my room. God bless you.

"Mr. Parker"

Mr. Parker (not his real name) was referred to me by Extern Chaplain Sue, who had visited with Mr. Parker and was assisting in his discharge plan that was running into some difficulty. Because of her questions, she came to me and asked if I would visit with Mr. Parker. The following visit took place:

Mr. Parker is a thirty-nine-year-old African-American male (he looks much older.) He has been hospitalized for four weeks with an abdominal injury caused by a gunshot wound.

CW: Good afternoon. My name is Cecelia Williams. I'm one of the chaplains here with the hospital. I understand that you talked with Chaplain Sue, and I wanted to come and see how things were going with you, and if I might help you in thinking about where you are going to go when you leave the hospital.

MP: I talked to the social worker and them, and they said that there was a place over on Grace Street until maybe I get well.

CW: Well, that sounds like good news. How do you feel about that?

MP: That's okay.

CW: Do you mind talking with me about what brought you into the hospital?

MP: Well, you know, I got shot up in my stomach, and that's what happened.

CW: Do you remember anything about the incident at the time?

MP: Well, yes.

CW: Do you mind talking about it?

MP: No. I was coming down the street over where we kind of hang out in this house. I had been there and I was coming out. It's kind of in the alley. I don't know why, but somebody just shot me all of a sudden, and I was laying there. Then, something strange happened. [long pause]

CW: What happened?

MP: You see, about three weeks prior to this, my friend's mother was trying to put a marker where he had gotten killed. He got shot up there, too. I helped her put the marker up, but about a week later, someone tore it down. I saw her working to try to put it back up and put some flowers there, so I stopped and helped her. You know, after I got shot and I was laying there, probably just bleeding to death, my friend came and got me.

CW: Your friend came and got you?

MP: Yes. I could see him, and he dragged me, he pulled me all the way down to the end by the street, so that somebody could see me.

CW: That's interesting. What do you make of that?

MP: Well, I think that's the way God was saving me, by having him come back and pull me out.

CW: Let me get this straight. Are you telling me that your friend who had died several weeks before . .

MP: [interrupts] Yeah, about a month before . . .

CW: . . . came and pulled you out to the street?

MP: Yes. That's what happened.

CW: My! That sounds miraculous. A really miraculous thing. What do you think about that?

MP: Well, I just think that's the way God saved me.

CW: You know, Mr. Parker, if God saved you, what do you think you need to be doing with your life at this time?

MP: I'm not sure about that. I've been thinking a lot about it, but I'm just not sure about that.

CW: What kind of work do you do?

MP: I don't know. I've had a lot of different jobs, but I've never had a job for a long period of time. In the past thirteen years, I've probably had . . . I've had a lot of jobs, but I've never worked on any job longer than a couple of months.

CW: Why is that?

MP: You see, I've had a drug problem, and I can't do drugs and keep a job. I haven't been able to quit the drugs, so I keep losing my jobs.

CW: I see.

MP: I would like to change and do better. But, I don't know, it s been so hard.

CW: Do you think that now things will be different?

MP: I'm hoping and praying that they will.

CW: Mr. Parker, do you have a family or someone that you're close to?

MP: No, not really. I had a grandmother. She's the one who raised me and helped take care of me all the time. But, three years ago, she died, and there ain't been

nobody, really, since that time.

CW: I see. So, you've just kind of been around the neighborhood since that time?

MP: Yeah. Just making it from day to day. Nothing special. Just making it from day to day.

CW: Is there a particular way that you would like to see your life go?

MP: Yes. I d like to have a good life like anybody else . . . a family, and all that. But, with the drugs and all that, I never did have enough money to ever have a real family.

CW: I believe that things could be better for you. You have told me about an experience that demonstrates God's love for you. I believe that God's love is still present in your life, and that the same love of God that was present for the spirit of your friend to come back and pull you from the alley will be present with you as you go forth. I was wondering, Mr. Parker, would it be okay if I invite Mrs. Barnett, who is our drug rehabilitation counselor, to come up and visit with you? Maybe she can give you some recommendation on treatment to help you with your addiction.

MP: Oh, that would be fine. That would be fine. I know about some programs that are down in Hampton, but I don't know about anything here, so I really would like to know that. That would be real nice of you. I hope you'll do that.

CW: Okay, I'll have her come and see you. Do you mind if we have a word of prayer together before I leave?

MP: No, that's okay. I'd like that. [MP extends his hand, and prayer is offered.]

The Prayer:

Loving God, we thank you for who you are as our God. We thank you, Lord, that, in the midst of this tragedy, you have seen fit to send your Spirit to be his Savior. We thank you, O Lord, not only for what you have done to save him physically, but what you have also done to save him by giving your own Son, your Son giving his own life so that he might have life eternal. We ask, O God, that you would open up his heart and his mind . . .

This encounter draws to a close with recommendations to talk with the substance abuse counselor and the social worker about making plans for him as he is discharged. He'll be going to a halfway house.

Sociological

The patient is an African-American male, unemployed, with many years of substance abuse. His family support is practically nil, and he is considered among the marginalized in this city, not having any of the resources that it takes to maintain life. The hospital bill will have to be absorbed by the State of Virginia, since he has no resources. This man is open in his relationships and willingness to talk about his concerns.

Psychological

The patient has lowered expectations of himself and has chronic addictions. He is very dependent upon alcohol and drugs. This has become a way of life for him. However, he was approachable and willing to discuss issues with the chaplains, nurses and others that he had encountered. He has lived in many of the halfway houses that have been provided in the neighborhood.

Spiritual

The facts that this patient does not attend church and has no formal religious affiliation, do not limit the power of God to be present with him at.the point of his need. When he was on the ground, having been shot, he recalls a spiritual event that causes his life to be saved. What I learned from this is that God is present where people are suffering and where there is hurt. The patient adds a spiritual interpretation to this, in that he believes that God has something that he wants to do.

He has proven himself to be a friendly sort of person by assisting his friend's mother in placing a marker at that very site. The concerns for the patient are where will he go after he is discharged from the hospital, will he be able to work again, and what will be the outcome of his release?

Summary

This chapter consists of 15 ministry reports from seven different chaplains, with victims of violence at MCV. The stories are as different as the men who tell their stories, about how their particular injury occurred. These reports also provide some insight into the type of lives they have led. In some cases, they provide the insight into understanding how their lifestyles may have contributed to getting shot, stabbed or bludgeoned.

There are some things that are similar. For instance, all experienced fear of being killed. Many of the men were surprised that they were injured. Generally, they all expressed gratitude that their lives were spared. It is common that they acknowledged that God's presence was with them from the time they were assaulted until they were in stable condition.

Drug addiction was the most common cause of a lifestyle that involved crime to support their habit. There was no known reason why some were shot, they were simply in the wrong place at the wrong time. It was not the first time that several of the men had been shot or stabbed. Many reported that this was the third or fourth time they were injured. Each time the injuries were worse. The physical injuries reflected their internal, unresolved emotional tragedies, such as abandonment, alienation, poverty, and grief.

The full extent of the damage to some of the patients was not known at the time of the interview, be we do know that their lives will never be the same. The injury was a life-changing event. After surgeries and rehabilitation, some will live with spinal cord

injuries that caused paralysis or they will need to wear a colostomy permanently.

These ministry reports are of actual pastoral care visits. The quality and skill of the chaplain who is offering the care is not the reason for presenting these reports. My intention is to inform and to share with the reader the debriefing of the victim. Telling their story to a caring minister allows victims the opportunity to debrief, submit and relinquish the spiritual pain of the event. The most positive outcome of the injury is for the victim to be transformed from a lifestyle and living condition that puts him at risk for revictimization or is certain to lead toward incarceration or death.

CHAPTER FIVE

INTERVIEWS

Dr. Napoleon Peoples, Ph.D.

Dr. Peoples is a Professor of Psychology at the Virginia Commonwealth University. His specialty is multi-cultural and diversity training. He has been a consultant for corporations, educational institutions and has conducted workshops and seminars throughout the United States. Dr. Peoples regularly presents a multi-cultural seminar to CPE students who are preparing for the chaplaincy or work in parishes as pastors. The Department of Pastoral Care at MCV Hospital adds this seminar to its curriculum to help CPE students become aware of their own biases and to help them to accept differences in culture and attitudes that are found in others.

Dr. Peoples is well informed about the needs of this community, having taught and practiced here for more than 20 years. I found his insight into this problem very helpful because it helped me to understand how the social condition impacts the events that have developed over a number of years. Dr. Peoples and I began this interview with the following questions:

CW.: Why is there so much violence in the Richmond African American community?

DR. PEOPLES: The loss of elders within our community, where role models for youths is a large problem. Individuals that presented a strong positive image of success with high values of hard work and determination are absent. It is important for youths to know

black professionals. The loss that many black communities face is the absence of leadership and wisdom. Black professionals used to provide regular consultation to friends and neighbors within the community. When teachers, doctors, lawyers and preachers lived with nonprofessionals, there was a positive direction, discipline, encouragement and leadership. They set a positive example of high standards of values. Success of the elders was not only measured in material achievement, but their lives were dedicated to making the community a better place. They spent time talking to young people and offered advice on how to navigate a social situation that had within it limitations for employment, education and housing. However, it was with their help that those who were less fortunate were able to receive help to rise to a higher standard of living.

Segregated housing patterns prevented upwardly mobile families from moving into suburbia until the middle sixties. Before that, many families were composed of extended families, having older relatives living within the home or nearby, which provided support for the nuclear family. People lived closer together and were involved in each others' lives. It was common for older people to confront youth about their behavior. The role of the elders was seen in the black church also. Their youths participated in activities that affirmed them and gave them confidence. This was also a kind of extension to the family. There were mentors and supporters found in groups of elders in the church. People who "made it" invested in youth. Rites of passages were experienced through activities at church that produced confidence in them. These activities included performing plays, learning and reciting passages from scripture and

having Bible quizzes. Values were taught in Sunday school and youth groups.

The loss of elders has caused a tremendous sense of disconnection. Youths find it difficult to feel connected to a social network where they eventually will become the elders. Leaders today are dealing with their own self-interest and inflated egos. There are no more "servant" leaders, persons who utilize their gifts unselfishly. An example of this is that, "my father died when I was only ten years old. Our pastor, the Reverend Donald Ming in New York, and his wife spent time with me and other youths and always asked us to bring report cards and other evidence of how we were performing in school. They showed an interest in what I was doing.

The integration of housing in the sixties and seventies opened opportunities for housing outside of the black community. The black middle class left the black community and moved away to suburbia and elsewhere. The abandonment of the black community by the middle class is almost complete. Some return for weekly visits to churches that are still located in the ghettos. Generally these churches are closed during the week. The exodus of the middle class left the community without protectors, so there were no voices to speak up for the community.

Youth do not have positive role models of individuals who achieve through hard work. They do not see men who conduct themselves as respectful fathers, that work hard and are involved with their children.

The availability of drugs within the community is an example of the lack of protection for the community. Anyone can see drugs being dealt openly and this is what looks like success. The clothes, the cars and all of the other things that are produced

from revenue from drugs are what youths are seeing as successful these days.

The negative factors include the destruction of the family. Males are reared by women without men to provide a definition of what it means to be a man. Our culture no longer offers rights of passage that represent a certain level of accomplishment and acceptance by the elders.

Gangs offer for some youths the only organized social group where they are able to find a place. Activities in the Boy Scouts and other activities that have traditionally supported youths are now absent. Crimes are committed within the gang structure to prove that they are "men." Youths are used to commit crimes. Some have committed shootings or murders, and are used to drugs. The idea of what a man is, is for many youths the TV image which portrays black males as aggressive with guns. They are disrespectful of women and use the women. Boys experience abandonment, abuse, rage and hurt. They feel betrayed by adults. Promises by men who may be the mother's boyfriend are often broken. Responsible men are absent from the home. What do the mothers do with this absence of men from the home? They tell little boys five and six years old, "You are the man now." They call them, "My little man." Women need to stop telling boys that they are men. The relationship that boys see between men and women represents mistrust, lack of respect and responsibility. Boys need to be taught to have a responsible child's role in the family. Mothers need to keep a realistic balance about what to expect them to be able to do and not expect them to function beyond where they are able to function. Mothers need to empower them as well as nurture them. They need to allow them to accomplish some things on their own, yet not expect them to

perform like adults. Women convey the idea that men are providers. Some boys seek to earn respect in fulfilling that role by providing support for the family by selling drugs, buying things or giving gifts to their mothers. Some mothers ask no questions and just take what their children bring. Mothers have a role that could lead males toward emancipation. They need to offer appropriate values and responsible behavior in the family. What often happens is that the boys act so disrespectful in adolescence that they wind up getting kicked out of the home long before positive family values have become a part of their character.

CW: What needs to happen?

DR. PEOPLES: Young men need surrogate father figures that will help them to find themselves as young men in nonviolent ways.

CW: Dr. Peoples, why are the young men killing each other?

DR. PEOPLES: Most are acting out of rage that comes from the hurt of abandonment and abuse. They lack respect for themselves and others. In fact, some of the homicides are a form of suicide. They are trying to destroy themselves. It's their death wish. Youths feel "out of the loop" disconnected, and disrespected.

CW: What can be done to prevent this destruction?

Dr. PEOPLES: We need to try to focus on the five- to ten-year-olds. Older children are already so damaged that programs would do little to impact them. The churches need to use the resources of professionals within the congregation to design programs for men and boys and to provide a positive image for them to use. Youth traditional organizations, like Sunday School, need to change in a contemporary way. They must be

interesting and must involve the youth. For instance, the song Stomp by "God's Property and Kirt Franklin" gets the youths' attention. The rhythm naturally fits them. Positive learning can be ingrained in their psyche like the negative messages that are being put in them by some of the rap music. Make Sunday School a party. Children need to be excited and enthusiastic and they will want to get there because they can have fun.

Set up situations like summer camps to produce values and opportunities for them to develop confidence through sports activities and to share in fellowship. The presence of positive adults is needed. Rites of passages can be developed in the church. Many churches are uninteresting and their programs are not attractive to youths. Emphasis should be placed on reaching out and building relationships that help young men feel "in the loop."

CW.: Thank you very much Dr. Peoples for your time.

Barbara Egwim

Barbara Egwim is a survivor of violence. Her son, age 23, was murdered January 3, 1996. Barbara and I will be discussing that incident, what the effect has been on her, and how she is transcending from this trauma and the grief.

(B = Barbara; CW = Cecelia Williams)

CW: Barbara, would you mind just talking into the tape, and identify yourself.

B: My name is Barbara Egwim. I am a survivor-victim of homicide. I lost a son, Koran Stewart, on January 3, 1996. My son was an employee of the Commonwealth of Virginia. He was also married and an expectant father. At the time of his death, his wife was in her fifth month of pregnancy. I now have a beautiful grandson who was born May 4, 1996, not knowing his father. Well, not necessarily not knowing his father. We will always talk about his father; he will always know his father, but will not be able to have his father, touch his father, feel his father.

CW: What's his name?

B: His name is Koran Stewart, Jr. My son died as a result of a gunshot wound. He was shot January third. This was a spin-off from an incident that happened in August of 1995, when he corrected a young man for throwing a rock at his car

while visiting one of our relatives. Little did we know at the beginning that this would be the conclusion and would result in his death.

CW: Was there an argument in 1995 between him and . . . who was the other person?

B: Okay, there was an argument in 1995, with the rock-throwing incident, with the brother of the murderer of my son, whom he corrected for throwing rocks at cars as they went up the street.

CW: How old was the person who was throwing rocks?

B: At that time, he was seventeen years old. On January third, the brother that was involved in the incident in 1995 was with his older brother, who had a history of being in-and-out of juvenile detention. They were with two other people in a car. They spotted my son leaving a store at a shopping center and pulled into the parking lot, jumped out of the car, confronted my son, and fought him. Witnesses say the only thing they heard was, "Why did you call the police?"

We checked police records. This happened in Henrico County. We checked police records, and there was no record of any calls to the police at any time with my son giving his name. Even after my son's death, when we checked records in Richmond City and Henrico, there was no call entered in my son's name. But, of course, people can make anonymous calls. Right now, there are still some unanswered questions, as far as I'm concerned, about the findings of the case.

CW: Are there details that would satisfy you, knowing about the case?

B: Absolutely, so I could have closure.

CW: So, the details for you are that in the argument that was going on, they accused him of calling the police, and he had not called the police.

B: That's what witnesses say that were around, that did see the incident. During the time of the investigation, there was no one that came forth and said that they knew who the individuals were.

CW: You say they did?

B: They did not come forward. I don't know if that was out of fear for their own lives or just what the situation might have been. I understand that the young man that murdered my son had a very bad reputation, and he was feared by quite a few in that area.

CW: So, there's a sense in the community that people knew that there were others around who had witnessed this. How do you know that?

B: Because I got this information from the Henrico investigator when he asked in the stores and found people that were willing to speak. The only thing they said was that they got out and said, "Why did you call the police, man?" The next thing that happened, four people were fighting with my son.

CW: Your son was alone?

B: Yes. Like I say, there are still a lot of unanswered questions. This information, even with the rock throwing . . . it was very hard during the time that my son died, of course. Then, at that particular time, we had one of the worst snowstorms in '96, in a long time, for Richmond. Everything was just at a standstill. We had to postpone the funeral service three times because of the weather.

CW: That was the real ice storm?

B: Three times we had to postpone and call back the newspaper, put it in three times. Then, finally, when we were able to have the funeral on the day that it actually stopped snowing. We were able to have the funeral services, but were unable to bury him.

CW: The ground was frozen.

B: Right. And, we were not able to bury him until two days later. That was very, very sad.

CW: Okay. We're skipping around. I want us to go back. You're all the way at the burial and you haven't talked about the incident itself. How were you notified?

B: I was notified by my cousin.

CW: She saw it?

B: No, she didn't see it. But her younger son saw it and someone ran to their house because she was not far from the area of the shopping center and told them that my son had been shot. Immediately she got on the phone and notified me. At that time, I was shocked, and I called his home and asked his wife, "Is Koran there?" She said, "No, he went to the store, and he should be on his way back." I told her, "Patricia, don't get excited . . ." I wasn't really thinking, but with her condition and being pregnant . . . I said, "I just got a call that Koran has been shot." So, she dropped the phone, and I called "Patricia, Patricia!" So, then I called my kids' godmother, who also lives close by, and told her. She had to pass by the area to get to me. I said, "I just got a call that Koran's been shot." I said,

"Go there. . ."

CW: Where was the location?

B: On Laburnum Avenue. I said, "Go there, and come by and pick me up." Well, she went there and with the situation as it was, I was dressed and waiting and pacing, you know, trying to get there. I guess, with all that was going on, she was crying and trying to get us into the store where he had made his way back in and collapsed. When the emergency services came and took him, she immediately followed the ambulance to MCVH.

CW: So she followed the ambulance to MCV Hospitals and you still had no ride to get to the hospital?

B: At that time, I said, "Something is wrong," because I really knew then that something was really, really seriously wrong. I ran out the door and went to a neighbor's house and asked them for a ride to MCV. They immediately took me there. By the time I got to MCV, my son was dead.

CW: Was he dead upon arrival?

B: He was dead upon arrival.

CW: Where was he shot?

B: He was shot in the neck.

CW: So he bled to death before arriving at the hospital.

B: When I got to the hospital, my daughter-in-law had gotten there by that time too. We were all crying. The chaplain was there. I asked to see Koran, and he suggested that it probably wouldn't be a good idea. Then, his godmother, who is

also my best friend that watched him grow up, she said, "She's a nurse." The way he was shot, you may not want to see this right now because she also knew what it might look like. They also told me they had to break open his chest, and they hadn't cleaned him up. So, at the time, that was okay. That was okay. I was like, "This didn't really happen. He's going to be okay. I'm going to see him when you clean him up." You know, at this point, it didn't really matter because I'm going to wake up out of this pretty soon. I was in denial, in shock, in awe.

CW: Physically, how did you feel, Barbara?

B: Frozen. I'm not going to say lifeless, but just sort of dazed and . . .

CW: Numb.

B: Numb. That's the word.

CW: Did you cry?

B: Yes, I did. Yes, I did. I cried. I broke down and I cried. And then, at one period, I dried completely up, and it was like this boost of energy came. You know, like, this has not happened. I was in and out of denial momentarily, and still not crying because they said my child had been murdered.

CW: Did the doctor come out to tell you that also?

B: Yes. We talked to the doctor, too. He's the one who actually talked about the chest wound, the chest opening. And he suggested that this was a mortal wound. I then asked for a phone and called my family, my immediate family in Charlottesville and notified them what had happened. Patricia, my daughter-in-law's family came down. I had support from all aspects of family.

Then I talked to the Henrico detective, not the one assigned to the case, who gave me the card to notify the detective that would be assigned to the case. Then, I was given a packet of information for people who had lost a loved one.

CW: A "bereavement packet."

B: Yes. That's what it was.

CW: Did it mention anything about people who had lost someone who was murdered?

B: Yes, it did.

CW: Did you find it helpful?

B: Yes, I did. I was somewhat familiar with that, too. You know, through the "Victim Services Section."

CW: What happened next?

B: We left the hospital and came home. I insisted that the route we take would be to leave MCV, go down Mechanicsville and up Laburnum Avenue that way and past the site where my son was murdered. At that time, the tape was still up.

CW: The yellow tape?

B: Yes. The stores were closed, and I continued on home.

CW: What time of day was this?

B: My son was murdered at 7:50 that evening.

CW: And the store would normally close at what time?

B: I'm not really sure, but I think they close at 9:00..

CW: Was it closing time? Would they have been closed also because of the crime scene?

B: Right. So, I continued home and my family arrived from out of town. The people who knew me had seen the news break and as word traveled, my phone constantly rang the whole time. We were trying to notify other family members—my ex-husband, my son's father. He was on vacation. I didn't have any information. So, the main thing was trying to contact him to let him know what had happened. I had everybody in the city where I was from who knew where he might have been trying to contact him to let him know that his son had been murdered. Then, I guess I got to bed that night probably about 2:30 in the morning, and the next morning I went to bed, and it was like I was so drained. I was in the bed looking at the ceiling, in the dark, with my eyes open, and I thought, "This is not happening."

CW: It did not seem real.

B: Right. It didn't seem real. I was just completely numb. I didn't mind it being quiet. I just lay there. I don't even know if I went to sleep.

CW: Considering your behavior at the hospital, and looking at your behavior in the days immediately following, could people detect that you were bereaved?

B: At the hospital?

CW: Or would they think that you were pretty calm?

B: I don't know.

CW: Would people say, "she's taking it really well" or were you upset?

B: I would think so. I'm only going by things I've seen on TV when I've seen other families on the crime scene and they show on television how the people break

apart. I wasn't like that. I was totally the opposite. But I had a strong desire to visit the crime scene. I did that. I asked a lot of questions of the store owners.

CW: You were still in shock with a lot of disbelief. Did anyone ask if you would mind donating organs?

B: No. No one asked that. I found out almost six months later, when I finally had the nerve to go through the personal belongings that they had given back to us, that my son had on his driver's license for donor, "undecided." Where at that time I said, okay well, I need to find out whether or not he was a donor because I didn't understand what "undecided" meant. Then I looked at my driver's license and I didn't have that on it.

CW: Well, it means that you have not decided whether you want to donate.

B: Right. But, I didn't know that because of that they would make the decisions themselves.

CW: Oh, no. They don't do that.

B: I didn't know that. I called the Medical Examiner's Office. I called DMV. When I discovered this it was on a Saturday. The representative at the DMV wasn't sure, so that alarmed me a little bit more. So, then the next Monday, I called the Medical Examiner's Office and questioned whether or not. So, then I found out. I called back to DMV that Monday and talked with someone else and found out that if "undecided," it would have to be up to the family members.

CW: It always is. You planned the funeral and you had the delays because of the weather.

B: But, prior to planning the funeral, let me tell you this also. Of course, I had to get copies of the program for the funeral. This was at Kinko's. While at Kinko's, I was sitting there with the representative and the representative was waiting on us, the kids' godmother had taken me there, because she was my source of transportation throughout the whole time. We were sitting there and all of a sudden in the door came a lady. I saw her when she entered the door because I was facing the door. My best friend, the kids' godmother, had her back to the door. Of course, in that type of weather nobody came out, especially in heels and dresses, because it was not that type of weather. You dress comfortably with your boots on or whatever, because of the conditions. When she came in the door, she just came straight to us. I sort of noticed her walking toward us, but I thought at some point that she would go left or she would go right. All of a sudden, she was standing a little distance behind the kids' godmother. I was facing her and I looked up at her a couple of times. She smiled. I smiled back the first time. Then she kept standing there. I thought, "This lady is very rude," because she could see the clerk is waiting on us. At the time, he was typing in information. And I thought, "Why is she just standing there?" as if she was just standing there thinking, "I will just stand here until he sees me, then I will interrupt." Then I became a little angry inside and I looked up at her again and she smiled again, and I did not smile back at her this time. Honestly, I looked at her eye-to-eye, thinking, "You're not going to interrupt us. I don't know who you are, or why you're standing here." And, each time I looked at her, she was smiling. And

then, all of a sudden, after I gave her the eye-to-eye look without a smile, she went into her pocket and pulled out a pamphlet and gave it to me.

CW: This tract?

B: Yes. She handed it to me and she handed it to me with her finger pointing to what she wanted me to read.

CW: [reading from tract] "Jesus said, I promise that the soul that will honor this image, will not be destroyed." (See appendix.)

B: And the thing that was so amazing about it was that, [tearfully] as a child, I just always wondered where did African-Americans stand because every image I had ever seen was of a white Jesus with blue eyes. And I always questioned that as a child. As I got older, I came to realize that God is a God of all people. This woman was Caucasian and she gave me a picture of a black Jesus. It was as though God was saying, "In your time of need, I want to let you know, I'm a God of all people. And I'm sending this white angel to you with an image of God being black." That was very, very touching.

This lady, at that time, turned to walk towards the door and the kids' godmother got up to run to catch her. When the lady went out the door, there was no way possible for that lady to disappear walking, even to the next building. The time frame was impossible. She would have caught her either going into a building or getting into a car. She went out to find this lady. This lady was gone. She was nowhere to be found. Oh, I'm sorry. She went to the counter before she left and she told the young man at the counter that she was there to see a

representative because she comes in now and then to say hello to him. The man did not even know who she was. And, on top of that, he doesn't even remember seeing anybody then.

CW: What do you think this means?

B: I know she was an angel. I know that she was an angel and I know that she was sent to me at that time to let me know that things were going to be okay, that God was going to be with me through whatever it was that I had to endure.

CW: She was sent to you to give you a sign that you were not alone, that God was going to be present and sustain you through this.

B: I believe this.

CW: And this message comes to you in a very mystical way, through an angel?

B: Yes.

CW: And you took that as a source of strength?

B: Yes. I took it as a source of strength. After we left Kinko's, I returned home with the information and the printouts and stuff that I had.

CW: The funeral program?

B: Yes. Not knowing at the time that the information would be different from what we actually had to do because the weather didn't permit things to happen on the day as planned. But I didn't re-do any of the printing. We just got the newspaper to change the date. We finally had the service and my son was buried. I went through a period still in denial, still sort of numb. I returned to work. Now that I think about it, everyone was sort of surprised that I was there so soon because I

was still in denial, not understanding what it was. Because it was just like he's going to walk through the door. I thought I'd come home and he'd be in my kitchen getting stuff out of the refrigerator or asking for a bowl or a pot of something and taking it home.

CW: How long had he been married?

B: He was married August 3rd in '95. So he had only been married for five months when the murder occurred. I returned to work and after returning to work, I really sort of got in touch with reality.

CW: Feelings kicked in.

B: Yes, kicked in. And I had to pray to God. Luckily I was on a very fast-paced job and it keeps you busy constantly, which was very therapeutic. If it had not been I don't think I could have made it, even with the help of the Lord. But I asked God to help me through this because I knew I had committed myself to come back in early even though I could have taken more time. I thought I was ready but I wasn't, because the reality hadn't kicked in at that point.

CW: Did that delay you from getting more in touch with your feelings? Or was that a help to you?

B: I think it really helped a lot. I don't think it delayed me from being in touch with my feelings. I think it really helped a lot. Where I work, I'm seeing a lot of literature on exactly what I went through. So, to constantly have things that are reminders was therapeutic because it gave me something to make it through. One day, during the time of coming back to work, one of my co-workers gave me an

article on a woman that was in Norfolk that was doing a "Healing Wall." In the newspaper article from Hampton Roads, it had her phone number. I called her. I told her who I was and how I had come across the information. I told her some of my interests. At that time, I had also met a beautiful person that I still work with in the community. Her name is Linda Jordan. She lost a son seven years ago and she had a statue built at City Hall, "River of Tears." I told her about Ms. Jordan and my working with the Urban Violence Project Committee and the statue, "River of Tears," and just tried to share ideas with her. The networking was great.

CW: Linda Jordan is in Richmond?

B: Yes. We talked for the first fifteen minutes with on and off conversation. Then all of a sudden she got very quiet. I said, "Hello." And she said, "I really don't know . . .," this is exactly the way she said it, [audible sigh], she sighed and said, "I don't know if I should say this or not." By that time I was puzzled. It was the first time talking to her. What is it that she might be hesitant to say? And she said, "I want to tell you about a dream and I'm almost positive, your son." I said, "What was the dream?" She said, "I lost two sons." I knew this because of the article. She lost one in New York. She left New York because of the crime rate, moved to Richmond and her second son was murdered coming home from his job. She said she had never dreamed about either of her sons. That particular night she had a dream about the older son, the first one that died. She said in the dream he took her to the stadium and the stadium was full of nothing but youths

that had died and he was introducing her to different ones. And he brought her to this young man and he told her, Mommy, this is a friend of mine. She went to him. [Tearfully] She described my son exactly to a "T." She told me he was tall, possibly six feet, four inches tall.

CW: You talked with the woman in Norfolk who is establishing a "Healing Wall." What is the "Healing Wall?"

B: The "Healing Wall" is a wall that bears the names of people that have died as a result of homicide. The first wall was in Virginia Beach; the second wall is in Norfolk. When I received information on this, a newspaper article from one of my co-workers, I phoned the lady to let her know what we were doing here in Richmond with Ms. Jordan.

CW: And she shared this wonderful dream with you. In that dream she had seen an image of your son . . .

B: Yes, of my son. And the most amazing thing about it—when she called me back—I was like, sort of stunned, you know, but not really convinced. Because I said, you know, she could have been just guessing. I had never seen this lady. She had never seen me. She didn't know I was going to call her. I didn't know I was going to get this newspaper article.

CW: So there was no reason for her to give this description or tell you this?

B: Absolutely. But what really, really, really convinced me was that she told me that he gave her these two dolls. And he said, my mother's going to be calling you, [tearfully] and when she does, show her these two dolls and she will know who

you are. My son had two dolls that he had won at the State Fair, a male and a female bunny and whenever he made his bed when he lived at home with me, his bed was not complete unless these bunnies were on the bed. And these were the two bunnies that she was talking about. I asked her then, I got quiet, because I said . . .

CW: No mistake . . .

B: No mistake. I said, "What do these dolls look like?" She said they were two black dolls, a male and a female and these bunnies were two black bunnies, a male and a female.

CW: Are these the bunnies?

B: Yes. A male and a female that stayed on his bed every time he made his bed. It was not complete until those dolls were there.

CW: What do you make of that?

B: What I make of that is that my son is letting me know [tearfully], "Mom, it's going to be okay. I'm still with you, even though I'm not there with you. But whatever you do, wherever you are . . .

CW: So this is a spiritual message.

B: Yes, it's a spiritual message. A spiritual message. I was very convinced then. I mean I just had to drop the phone at one time. And then, when I did get myself together to pick up my phone, she wasn't on the phone then. But, she had information. Prior to this happening, luckily, we got all the basics out of the way, because after I hung up and I was still crying, she phoned me back to see if I was

okay. She was very apologetic because she was scared. She didn't know what condition I was in, and she was really sorry because she maybe shouldn't have told me. I told her, "No, this is something that was meant for me to know." I had no idea I was going to get this. This woman had never met me. I had never met her.

CW: Something very special.

B: Right. And this was a newspaper article. I called her and when we were talking, I guess we were excited about what we were doing. And then, all of a sudden, it just dawned on her, this is the woman out of the dream two days ago.

CW: That's very powerful. Very powerful.

B: I still keep in contact with Jackie McDonald. Koran's name, once the wall is completed there, will be on the wall also in Norfolk. I have not, because of transportation, been able to get down there myself to see what they're doing, but we are communicating and sharing information on different things that we are doing.

CW: What are some of the things that you are doing that have allowed you to work with prevention, as well as other survivors.

B: First of all, like I said, I came under the wing of a person who had lost a son seven years before mine, Linda Jordan, whom I admired a lot because she, more so, was a person who had been out in the community . . .

CW: She's been a mentor to you.

B: Yes. It was just like I saw this lady and what she had done and how much she

had done and what she's trying to do—shared it and underscored it, because no one could understand better than a person who has walked in those shoes. Together we went on CBS, on "America" talking about the crime and the affect it has on victims in the Richmond area, as well as showing the "River of Tears" statue that she had worked so hard, for seven years, to get placed in City Hall . . .

CW: Now, I understand that the "River of Tears" statue was placed in City Hall and stolen.

B: No. It was stolen while it was at VCU.

CW: It was on display.

B: Yes and someone stole the statue from VCU. They did an investigation and they were unable to locate the first statue. Then Ms. Jordan had to find money to pay the artist to start another statue. When he was nearly completing the second statue, all of a sudden the first statue that was stolen was brought back to the gallery at VCU.

CW: So now there are two.

B: Well, there's only one at City Hall, but there ended up being two. The statue had a hard time making it to City Hall, but through the grace of God Almighty . . .

CW: So, someone just returned it.

B: Whoever stole it returned it right when the second statue was almost completed.

CW: Is there a brochure on the statue?

B: I don't believe so. I don't think so. All of the information is from the newspaper article.

CW: So you've been working with Linda on the "River of Tears" . . .

B: I'm a member of the committee.

CW: What's the name of the committee?

B: Urban Violence Project. This project with the statue was in effect when I came on board. I'm one of the last members on the committee. Linda Jordan was my source of strength, helping me.

CW: Was it a support group?

B: No, not really. It wasn't really a support group. It was just a committee with a dream of putting the statue . . .

CW: This group of people had a specific intent to acknowledge the people who have died with a symbol of a statue and to also honor the mothers who have cried this "river of tears" in Richmond.

B: Absolutely. That's exactly what it is for. Then I started thinking, well, we needed to get something ongoing because we need to really work on prevention. And then I thought about, because the crime rate is so high with juveniles committing crimes as well as the murder rate, as my grandmother used to always say, "When you see a problem, you nip it in the bud." And I said even though my son was killed in Henrico, the bulk of the crime is in Richmond. I said juvenile crime is the highest, as far as committing murders and being murdered. Why not take the victims in juvenile detention, share with them the impact it has on the family and the community and themselves, to let these kids know that we stand before them as people who have been affected and hurt the most, that we are here

because we care about what's happening to them. We want to spare their lives if possible by showing them the impact and the affect this has when it happens. The kids have to understand that somebody cares about them too. You have to turn it around in a positive way. I never knew the affect, even in my wildest dreams, of going into a program like that . . .

CW: So your program is to go into the juvenile detention center to share your experience with the juveniles who are awaiting trial . . .

B: The reason I say it's prevention is because all of these kids are not murderers, but their history is. They're very much at risk of becoming murderers. So this is what we're trying to do, to prevent that, turn it around. You can make mistakes, and you can still correct them. They're juveniles. They can turn it around. Once you become a murderer, there's no turning back. You're going to suffer. You're going to have to pay for that crime. But we're trying to prevent on that level and let them know people care.

CW: Okay. Internally, even if they were never convicted, they have reached a divide after they have taken someone's life. That's not like stealing. You cannot replace the life.

B: Right. Absolutely. And we're trying to show them the importance of their lives, that their lives are important.

CW: I want you to tell me about the person who killed your son.

B: The person who killed my son, to my understanding, was in and out of juvenile detention.

CW: So, then it's natural that you would go to juvenile detention centers as a prevention, because this is where, if he could have been saved, maybe your son would also have been saved.

B: And others. Because I was also informed that he was a suspect in another murder, but they couldn't prove it. So he was in and out of juvenile detention. At one particular memorial service I found myself standing next to the mother of the child who had killed my son.

CW: Explain that please.

B: He was murdered in August of 1996 in a confrontation with someone else.

CW: What was his name?

B: I'm not at liberty to give the name. I'd rather not give the name. But, he was killed in August of 1996 due to a confrontation, I understand from the Henrico investigator, with someone else. It was at that time really when they found out he was the murderer of my son. After his death, witnesses who knew that he had done it came forward and said that he was the one who had shot my son.

CW: These witnesses have waited how long? How many months?

B: My son was murdered in January 1996 and this young man was killed by someone else in August of 1996.

CW: That's a long time for them to hold that.

B: Yes. But even in February of 1996, when I was talking to family members and friends of my son about whether he had mentioned anything about having a problem with anyone, at one point the young man that started the incident in

August lived two blocks down the street from where my relative lived. The incident about the rock throwing came up then and I passed that information on to him and I said, "Was Irby there?" And it wasn't investigated because nobody knew that something as simple as the rock-throwing incident would have resulted in Koran's death.

CW: You did not have to endure going through a trial? For all of those months that you did not know who had killed him or if there was further revenge at all that they wanted. Was there anytime that you felt fearful yourself?

B: No. Believe it or not, no.

CW: What about Patricia? Was she afraid?

B: She was very afraid. Of course, reporters were ringing the phone and trying to get stories on it, and she didn't want to do any interviews, of course, because of the fact she was pregnant, and, at the time, we didn't know. Because, as a mother, even though I didn't see any illegal activity or anything going on with my child but, as a mother, and I feel every mother or father should be, you cannot say what your children will or will not do when they are not in your presence. Even though I didn't see any illegal activity I was open for anything. I just wanted to know what happened. I had no closure. And, as we were to find out, it was something with the rock-throwing incident, but of course they wanted to interview at the time like they do with any murder. They talk to the families. But, because Patricia was pregnant and fearful, I just said no because they had to do both of us together.

CW: And you and Patricia have a strong bond still.

B: Yes, absolutely.

CW: You are support for each other.

B: Yes.

CW: Have you dreamed about this incident at all? Have you re-lived it or thought about it.

B: I think about it all the time. I constantly think about it, but I have not dreamed have not even dreamed about my son since this happened. I constantly think about it. You see little things, or you hear little things that will remind you.

CW: When you met the mother of the murderer, the man who killed your son, and you found yourself standing in a memorial service a year later, and the woman who is weeping next to you is the mother of the person who murdered your son, who was the primary cause of your grief, how did you feel?

B: At that time, when I first realized who she was, when she cried and she went up and put her hand on her son's picture and I saw the name that they had given me and realized that was the picture of the young man on the wall and she was crying, standing next to me, the first feeling I had, in all honesty, was icy cold. I was icy cold. I wanted to turn and tell her to shut-up, shut-up, shut-up because your son killed my son. Then, it was just a weird feeling because all of a sudden this icy cold feeling was just momentary—it didn't last long at all—all of a sudden this warmth started from the top of my head and went to the bottom of my feet. And when I could feel it going down, then I began to get sadder and sadder,

and then all of sudden I started crying too and I was crying very hard, but my tears were for her. I realized at that time that this mother, even though her son had been in and out of detention, I don't know what the problems were at home or what the situation might have been that resulted in her son being that way, but I realized that I had to look at her, mother-to-mother. She was crying like I was crying. We both loved our children. And we both had lost our children. Her pain was no different than my pain. She hurt just like I hurt. And I had to forgive.

CW: So you had common ground with the mother of the murderer of your son, because he was also murdered.

B: Right.

CW: Did you forgive?

B: At that time I forgave. Because that sort of crying was—it was forgiving, it was...

CW: It was healing?

B: It was healing. It was because I was crying for her and me both. We both felt the hurt the same way. We both loved the same way. So, I could never hate her. [crying]

CW: God has been very good to you to bring you to this moment. Thanks be to God. Barbara, I'm aware that you are a member of a lot of committees and that you are very active in hoping to bring some resolve to this horrendous situation that we find ourselves in Richmond in this crises of violence. I want you to know that my prayers are with you, and any way that I can be of support, I would be happy to do so.

Talk about visit to Juvenile Detention Center

CW: Let's talk about our visit to the Juvenile Detention Center this past Tuesday.

B: Okay. On February third, I invited you, Miss Cecelia, to Juvenile Detention. And, when we got into Juvenile Detention, we had approximately ten youth there . . .

CW: Actually, we had fourteen.

B: Okay, fourteen.

CW: It was my understanding that I was going to just observe what was going on.

B: [laughter]

CW: I was shocked when you told me that I was the speaker.

B: Yes, yes. And I tell you, it was so beautiful, because of what you did at that time. You explained your job as a Chaplain, and asked them what a chaplain was and what a chaplain does. You explained what the functions were, talking to the families who come to (the ER.) of gunshot victims, and people that are dying, and how the families grieve. And then you also discussed with them some medical terminology like "gsw" and asked the kids did they know what that meant. Surprisingly, they knew a lot about it. They knew exactly what these initials stood for. It was just truly amazing. And then you talked with them about their goals and what they wanted to become. You went around the class and asked each one. They had such high expectations for themselves in the sense of things they wanted to do. This one particular lady, when you asked her what she wanted to become, she said a singer." You told her, "I love people who sing, but I'm not

a singer. At the end of this, I would like you to sing for us your selection." When we got to the end, the young lady stood up to sing. The kids were asking her to sing some of the new rap songs and I was standing in the back thinking, Oh my goodness! What is she going to sing? Ms. Williams asked her to make her selection and her selection was a beautiful selection. It was a gospel hymn and it was so appropriate, it was so amazing.

CW: "Jesus, I'm Your Child."

B: Yes. "Jesus, I'm Your Child." It was just so appropriate. I found myself so blinded by tears I could not see the class. I asked the guard that was in the section with us could she please get some tissues. There were none available, so we had to get a roll of toilet tissue from the bathroom to wipe our eyes. The guard was crying. The students were tearful. They were wiping their eyes with their hands. It was just truly amazing. I was so uplifted when I came out of there because that lady could have chosen to sing one of the R&B songs or rap songs.

CW: Well, afterwards another young lady decided to sing and she sang, "His Eye Is On the Sparrow." Some of these children, four of these children, are parents. Two of the young men said that they were fathers and two of the girls, mothers. They have aspirations and dreams and hopes for themselves and for their children. I felt very touched by that.

B: And especially the young man that mentioned, when he was asked, "What would you do differently?" He said, "I would get my life together because (even though he was young himself) I don't want my child to have to go through this." That

really touched me. It's not that these kids don't know that what they're doing is wrong, but they need someone to show them that they care about what they're doing.

CW: One young lady turned to me after describing an incident that her uncle had murdered her aunt. She described that in detail and then she looked at me and said, "Are you a survivor? Has anyone in your family been murdered?" I told her about the three people in our family that have been murdered. I have never been asked by anyone in an audience about my pain. It was a healing moment for me to share what I felt and to assess how I had gone on. So, I appreciated it.

B: It is amazing.

CW: You have been there on other occasions when the children have shared other things.

B: On one particular occasion when I was there, we had three students to break down in the class.

CW: You mean to cry?

B: Yes. They were talking about their pain. One young man was twelve years old. He has been in and out of detention since nine. The root of his pain was that he had lost his baby sister to crib death. He played with her the night before, before going to bed. He woke up the next morning and they wouldn't let him in the room where she was. And the only thing they told him was that she died of crib death and he didn't understand what crib death meant. So all this hurt was in him because nobody took the time to explain.

CW: Or honored his grief.

B: Yes. We console the adults, but we forget about the children and their feelings. And, as a result of that, he just rebelled, like, "I'm hurt and nobody understands my pain. I just don't care. I'm just angry."

CW: So he was acting out.

B: He was acting out. Then there was another young man who was in there because he watched his mother's boyfriend shoot her in the head and kill her in front of him and his brother. Ever since this happened, this young man has been in and out of detention.

There was another person that has confessed in this meeting that they had actually murdered people. Yes. And, he confessed to the murder. When we go into the sessions, I don't know who did what. I'm not at liberty to ask the children. If they tell us, then we know, but we can't go in with the knowledge because they are protected, as juveniles. He's in every session that I have. He requested to be there. A lot of the kids have requested to come back. That makes me feel good because I know my work is helping. The session before you came, I had seven young men stand up. "I want to tell you why they're standing," he said. "They have worried us to death about when you would be back." So, it's working.

CW: Thanks for inviting me. I felt very enriched by that experience. And, I just want to thank you for sharing with me and being "my teacher". You have traveled a road that I have not traveled. I have traveled with people who have suffered some

of the pain, but to be at the point where you are, and to have had so many interventions where God has been there and made Himself visible for you, I want you to know that I appreciate it. Let us pray together.

The Prayer

Loving God, you are our God. You sustain us when we are broken. You prop us up when we cannot walk by ourselves. We thank You, O God, that You have taken, through the tragedy, the fruit of Barbara's womb to Yourself. We pray, O God, for his spirit and for the spirits of so many that fill those stadiums in Your kingdom. God, we pray that You would heal our land of these tragedies. We thank You, O Lord, for the transformation and for Your healing Spirit that is so with our sister. Bless her as she goes. We pray in Your name. Amen.

The Reverend Rosalind Bradley

This is an interview with Rosalind Bradley. Reverend Rosalind Bradley is the sister of a young man Kenneth Bradley who was murdered in 1989. Kenny is Rosalind's younger brother and they were close both spiritually and emotionally and she still has a lot of feelings about his death. The reason why I have chosen to interview Rosalind is because she has shown that through the pain, grief and sorrow, transformation is possible.

(C = Cecelia Williams; R = Rosalind Bradley)

C: Rosalind, why do you think there is so much crime in the Richmond community?

R: I think partly peer pressure has a lot to do with it. I also think parents are not educated enough to steer their children away from crime at an early age. Another thing, especially today, too many parents are involved in the crimes. You have a lot of parents today who are drug users and abusers themselves. A lot of parents are not really focused on raising their children and I think we also have a lot of second and third generation poverty-stricken parents who really do not give their children a lot of self esteem or give them the notion that they can do better than they have done themselves. So you pretty much have this vicious circle that just keeps going around and around, where the parents really do not encourage the

children to think of themselves as moving beyond the level where they are—almost an acceptance of "this is our plight, this is where we are, this is where we will always be, this is where you are going to end up, and those who come afterwards."

C: A sense of despair?

R: A sense of despair and acceptance.

C: Okay. Before your brother was murdered, what was he like?

R: He was a person who really loved life. He loved living and he loved having a good time. He had a great sense of humor, but it wasn't as though he said things to be funny. He was more of a natural comedian. He could look at a true-to-life situation and say something about it and everyone else would fall out laughing and he would say "What are you laughing at? I am serious." To everyone else it would be comical, but to him, he was merely making a very truthful observation, but the way he said it would help other people to see humor in the situation. He really loved people. I think one of his downfalls and probably one of the reasons why he is dead now is because he really used the term "friend" too loosely. Almost everyone was his friend. Even people who at times became his enemy, a week or two later, they were his friends again. He was into, I don't want to say the world, he was into the street life. He was involved in drugs. I know for a large portion of his adult life he was involved in the selling of drugs. I think because he was selling drugs, my family did not live the horrors that a lot of families live when a loved one is involved in drugs. We never knew what it was

like not to trust him. We never knew what it was like to have him steal anything from us. We never knew what it was like to live in fear, except at times when my parents felt as though too many of his friends were coming by and staying a short period of time. My mother knew something was up and she felt uncomfortable having that many people just stopping by. But other than that, unlike a lot of families that have a loved one involved in drugs we never knew what it was like to get angry with him because of what he did to us. He never did anything to us because of his lifestyle, except break our hearts for what he did to himself.

C: What form did his addiction take? What was the drug of choice?

R: I believe, at the time he was killed it was probably cocaine. I am not even sure, I am not even sure if it was crack. I think maybe around the time he was killed crack was just getting on the scene, it was just becoming popular. I think mostly it was just cocaine. I know at sometimes he may have been involved with syrup, some kind of prescription cough syrup. But I think basically cocaine was the drug of choice, and probably some marijuana, but I don't think marijuana was really a moneymaker during his days of selling.

C: What would you say triggered his addiction?

R: I am not even sure to what extent he was addicted, if he was at all.

C: When did he start?

R: When did he start? During his teen years. I think he was mostly influenced by the group, the friends he made when he was young, the boys from the neighborhood basically. The group of guys that he started hanging out with from

the neighborhood, they all just seemed to gravitate to that style of life.

C: Did he graduate from high school?

R: He didn't graduate from high school because he always had disciplinary problems. My mom said he was born troubled. He was a very strong-willed, determined person. He went to John Marshall and had to leave there. He went to Walker and I am not sure if he had to leave there or if he just got tired and stopped going. But eventually he went back and got his GED. He was determined to get a diploma, so he went back on his own and got a GED. My Mom said he was always troubled. She said he was even born troubled. She said he was born fast. He was born at Richmond Community Hospital when it was over by Virginia Union. She said he was born on a stretcher before they could get her into the delivery room.

C: He was anxious to get here, huh?

R: Yes. She said he was born fast, he lived fast, and he died fast. And he was always quick. Even my husband, who used to hang with him a lot, said that sometimes they would go somewhere and there may be someone that my brother had a little problem with or an argument might come up. He said one minute my brother would be beside him and the next he would be flying through the air. Just real quick and quick tempered.

C: He was not a contemplator?

R: At times he was, but he was a very emotional person. When he was angry or hurt, he acted first. But there have also been times, my ex-husband told me, that even

though my brother could react very quickly, he would go somewhere and although he would have a gun on him, he would put his gun down and just have an argument with the person. And so it is almost as though he was quick to anger, but I guess he was slow to violence.

C: Would you mind talking about the day that he got killed?

R: Well, I can really start with the night before. I was in New Jersey. I had gone there on a business trip and all that night I could not sleep. I kept waking up, thinking something had happened to my son. At the time he was two years old. I kept thinking something has happened to Kelvin. Several times I thought about getting up and calling my mother-in-law, who was keeping him, but I didn't do it. The next morning I woke up with this sense that something was going to happen. That day I seemed to have a lot of "out of body" experiences. I mean, I knew it was me, I knew I was doing these things, but yet nothing seemed real. Everything seemed like it was in slow motion and I was actually watching myself. As I was getting ready to leave New Jersey and to catch the plane, I kept thinking, "the plane is going to crash." That didn't happen.

C: So you were having a premonition that something tragic was going to happen?

R: Well, it had started several days before that, when I had talked to my brother. The last two times I talked to him on the telephone, I had a sense that he was going to die. It was just that little small voice, because each time he said something to me, this voice just said "He is not going to be here" and I just knew. But I thought, since it was October and his birthday was in December, and he had

recently told me about someone who had died the week of their birthday, so I thought he was going to die right before his birthday. I didn't think it was going to be that week. And it wasn't the kind of thing that I could tell anybody, "Oh, I think he is going to die."

C: Did you warn him?

R: I didn't know how. I mean it was really one of those things and especially because I thought it was going to happen in December. I thought I would know what to do then, it was just the strangest thing.

C: So when did it actually happen?

R: The first time when I got the feeling that he was going to die was that Sunday and he actually died about 2:00 that following Saturday morning. So it was almost a week from the first moment that I just knew that he was going to die until it actually happened.

C: What was your initial feeling?

R: When I first had the feeling that he was going to die?

C: No, when you were told that he had been murdered?

R: What happened was that I had gotten a phone call from my mom, but before I got the phone call from my mom, something really strange happened. I was in the bathroom and this was about 2:00 in the morning, Saturday morning. Out of the blue, I just said to my myself, "If Kenny dies Momma will never have to worry about him again." I didn't even know why I just said that, although I think it was probably one of those thoughts that was always on my mind, because knowing

what he was into, that kind of life, I knew the possibility of him getting killed was always great. So after that I got into the bed and the phone rung. When I answered, it was my Mom saying that a friend of his had just called and said Kenny had been shot or something. So after I hung up from her, my husband was at work and the baby was sleep and I basically said, "So what should I do?" She told me she would call me back when she knew something and I just kept thinking, "Well, what should I do?" and so I decided to lay back down until I heard from her, because I was exhausted. But I said I can't do that, so I said I'll go wash dishes. And something said, "Well, maybe you should pray." I just said there is no need, because he's dead and I just knew. There was no sense in praying for his life, because it was already gone. So then I thought, "Well, I better call my husband," because he and my brother were really close and I figured if I didn't let him know, he would be upset, so I called him and he said "Well, I'll come home. Are you okay?" And I said, "Yeah." And he said, "You are really okay?" And I felt he really needed me to say no, so I said, "NO." And he said, "Okay, then I'll come home." But I knew he needed to come home more than I needed him there. And after he got there, we called and my Mom answered the phone. My other brother had gone down to the hospital.

C: Down to MCV?

R: Down to MCV's trauma unit. My Mom just started screaming, "He's gone." And so I told her we'd be over and I hung up. I told my husband, "Kenny is dead." Then we got the baby up and went to my mother's house. I guess

because I knew it was coming, it wasn't a shock to me as it was to everyone else. Mainly I was disappointed because I thought it was going to happen in December.

C: That is interesting. You don't say that he would have changed or something.

R: During that week, I just got so many messages that he was going to die, that basically, I guess, I had accepted the fact that he was going to die.

C: Mmmhmm. The trauma room that you offer your ministry to other victims, is the same room. Do you ever think about him when you are in the act of ministry?

R: Every time I go in there I think of him.

C: How does that influence what you do?

R: It helps me a lot when it is a victim of violence because I like to think I am doing something that I wish someone had probably done for my brother. Even though by the time he got there it was too late to do anything for him. I just like to think someone was there.

C: And someone may have held his hand . . .

R: Or just prayed for him or just cared about him as being more than a victim. I mean, just to me, it is important when victims come in, to see them as more than just a body that is bleeding, that is hurting, that is dying. But to think someone, somewhere is really going to hurt because this person is dying. It is just important to realize that person lying on that stretcher is a person.

C: With a life?

R: With a life, with a family, friends.

C: A loved one.

R: Many loved ones and especially a lot of loved ones who have probably been waiting for that moment, although they kept hoping that it wouldn't come, but was somewhat prepared for the phone call they got.

C: That is a scary way to live isn't it?

R: It is a very painful way to live. My family, we were extremely fortunate compared to the stories I have heard of other people who deal with loved ones who are in the drug world. Because we never had to hide anything from him, we never as much as experienced having to loan him money and not get it back, I mean, basically whatever he did it was to himself. It was never to us, we never felt the burden of his drug life. A few times he may have gotten arrested for some reason and I truly believe because we prayed so hard he was able to get out. But we started grieving from the time we knew that he was in that world.

C: Ok, so it was a lot of anticipatory grief that was already going on.

R: It was also a lot of guilty relief when he was dead.

C: Okay. That you did not any longer have to worry about what was going to happen?

R: If the phone rang after midnight, we didn't jump, thinking it was the call that he was in jail or dead or in the hospital. And that is what we lived with, all of us, we jumped if the phone rang after a certain hour. If he wasn't living with my parents, if no one had heard or seen him in a day or two, my Mom would call around and ask about him and then we would all live on edge until we got the word that he was okay. It was hell.

C: It's a roller coaster up and down.

R: Up and down.

C: Your Mother and Father, your parents, unlike many other families, have been married and reared their children together.

R: My parents have been married now almost 50 years, so they have been married all that time. One of the things that I think had a terrible effect on Kenny was my Daddy suffered a stroke in 1969 when Kenny was nine years old. One of the things I have learned since then is that it is such a crucial age for boys, because it is the age when they start pulling away from their mothers and start identifying more with their fathers. Where as my older brother had all the benefits of daddy teaching him how to drive and letting him drive and I think even the boy-to-man talks or man-to-man talks or whatever. When my dad had a stroke, even though Kenny was getting into trouble, it seems to just have a major effect on him. And looking back now, especially with the knowledge that I have now, I think a lot of what happened to Kenny was that he was grieving over the lost of my father as a whole man, because even though my father didn't die, when he finally got out of the hospital . . .

C: It was a physical loss.

R: Yeah, he was paralyzed on one side and a lot of the things that he did with my older brother, he couldn't do with my younger brother. The three of us and my dad did a lot of things together before my dad had his stroke. So I think for Kenny, he could still remember all those things that my dad did with my older

brother and realized he was not going to be able to do them with him.

C: He felt left out.

R: I think he felt left out, but I think the other part was no one recognized what was going on.

C: No one attended to his grief.

R: Yeah and even when he was having behavioral problems, the focus was on his behavior.

C: Not the cause.

R: Not the cause.

C: Did he have therapy?

R: He went to Memorial Foundation and Guidance Clinic.

C: Mmhmm..

R: He went there for awhile but I don't think it helped, well it helped and then it didn't help, because I think no one ever pinpointed what was really going on with him. And I think that was the lost of my father as the father.

C: The image that he had.

R: Yeah and then that coupled with his friends getting into their little world, their hormonal changes, trying to be a man. I just think it was a whole lot of things coming at one time and then with the behavioral problems, because my older brother took it upon himself to take my father's role in disciplining him and I think that caused a lot of problems. And so this is just looking back now and seeing things based on what I know now about grief.

C: So he was angry.

R: He was angry and he was very angry. I think he quite didn't understand because for several months we lived with the fear that my dad was going to die. And because my brother, Kenneth, and I were the youngest, after my dad had his stroke my mother sent us to Charles City to be with my Grandmother, that way she wouldn't have to come home and take care of us, so she was free to go to the hospital. But, it was always as though we were forgotten and we were almost cut off from the family because we were down in Charles City and almost everything we heard about my dad was what we overheard from my Grandmother when she was on the telephone. My Grandmother never bothered to come in and sit us down and say, "Hey, this is what is going on with your dad". We never had a choice as to whether we even wanted to go to Charles City and I remember my Grandmother took us to see my dad before we went to Charles City. This was when he was still in a coma and I think we both cried, Kenny and me, but my Grandmother told us to "just stop that, stop making all that noise." And so we just, I think we were pretty much left out.

C: The impact of this grief and anger and the loss was different with Kenny than it was with you.

R: It was very different.

C: You took this and decided to write and decided to do other things.

R: I think Kenny acted out his anger and his grief.

C: When did Kenny decide to stop going to church?

R: I think he stopped going to church, probably during his later years in high school. I guess it was the early 70s. He was very active in church. One of his close friends was active in Trinity. Kenny used to go with the family everywhere and they both joined church and they went together. They were ushers and went to bible study. He was very active. And I think it was probably during the high school years that he stopped going to church. But even though he stopped going on a regular basis, every now and then he would just surprise everyone and go.

C: Mmhmm.. So do you believe he had a spiritual connection?

R: Oh I know he did. I know he did. I think for all the trouble he got into and all the trouble he could have gotten into, people were always amazed as to how he managed to live so long and never pull any real jail time.

C: How old was he when he died?

R: Twenty-nine. I always say it is because so many people prayed for him, but I think Kenny prayed a lot for himself. I know he did.

C: Mmhmm..

R: I know he did.

C: Was he somehow managing his addiction?

R: I never felt he was addicted. I always thought of him as a user.

C: Are you still in denial?

R: I am not even going to say I am in denial. I say that partly because, like I said, we never had the nightmares that a lot of families have when their loved one is addicted.

C: Did he work?

R: He worked a lot, but even if he wasn't working, he was dealing drugs and so he was never a burden to us financially. I mean, there was never a time when we had to take care of him and at the same time he was never a big time dealer. He didn't get a chance to get big gold chains and never had a souped up car. The car he had when he died was an old, used car, so whatever dealing he was doing, he was never big time and we knew he was doing some dealing but it was never to a point where he could have been considered a major person and to whatever level he was using drugs, I have never seen him where his personal hygiene failed.

C: He was still taking care of himself?

R: He was still taking care of himself. Except for a few times when we could pretty much tell he was probably on something because of his mood swings. There were a few times when he was nodding, obviously he was so high that he couldn't stay awake.

C: You mentioned how your mother responded to this, how did your father respond?

R: My daddy was angry because he often said that of all four of the children, he was the happiest when Kenny was born. I think Daddy, without verbally saying it, felt as though he had failed in a way because none of us knew what to do to save Kenny. Daddy and Kenny often had really explosive moments and one of the things that really hurt, because my mom and dad were typical of a lot of mothers and fathers where the mother is always the soft, easy one, regardless of what the children do, whatever they want, they still give it to them and she can't stand to

see her children suffering. Dad was the one who wanted to practice tough love. So they were often at odds and so when Kenny died, I think it was hard for my Dad to show his grief initially. He did and I think it was important to him to let people know that he did love Kenny, but what Kenny did hurt him. He did not approve of a lot of things that Kenny did and he wasn't an enabler like my Mom was.

C: Was Kenny still living at home?

R: No, not at all, he had his own apartment.

C: Had he been married? Children?

R: He has one daughter. He has never been married. He came close one time, but he had never been married. At the time he died he had a girlfriend. They were talking about getting married and they were going to buy a house. In fact she had closed on the house the day he died.

C: You have taken this experience, along with other grief experiences in your life, and allowed them to make a significant difference in who you are. You want to talk a little about that?

R: Well, I think even before I lost the first person in my life, which was my paternal grandmother, and I think I was nine or ten when she died, which means Kenny was about five, I just grew up with my mother talking about people in her family who had died before we were born. She would just talk about them, about the time they died. She was present for several of their deaths.

C: Was she still grieving with it?

R: I think she was. I think she still is. In fact I think I just learned from her very early that grief never ends, that even when your loved one is taken away from you to die, you keep them alive by telling the stories, by constantly reaffirming your love for them, the importance they had in your life and by basically saying they lived and they meant something. So by the time my Grandmother died, I think I already knew what it was like to keep telling the stories and I think I already knew how important it was to remember her constantly. By the time Kenneth died, it was just a given that physically he's gone, but spiritually and emotionally he will continue to live as long as I live. And so it just became very important to me to hold onto that, but with Kenneth's' death, there was a lot of anger because of the way he died. There was a lot of guilt because I didn't know how to save him and a lot of pain because he didn't die of natural causes like my Grandmother did. And so, in a lot of ways, it just made it harder to let Kenny rest. My family has been accused of not allowing Kenny to rest. But I sometimes think Kenny won't allow us to let him rest, that even from the grave Kenny is letting us know we are still a part of him. And for someone who lived as much as he did, he gave so much, it is hard to just let that die.

C: You have continued to learn about grief in working with groups of people who are grieving. The awareness that you arrived at, how did that happen?

R: I think the awareness of me? How did that happen?

C: I mean, I understand that you understood something about grief and the pain of it from your mother and your own grief. It wasn't long after that, I understand, you

and your husband separated.

R: Two years after Kenneth died, we separated. And a year after Kenny died, my father-in-law died, and unlike Kenny's death, that was quick, my father-in-law suffered for about eight months before he finally died. We started grieving over him when we found out he had cancer, that he would probably not survive and as his condition worsened we just grieved harder. By the time he died, it was the same mixed emotions, there was some relief because he wasn't suffering. We had suffered watching him suffer but still the agony of knowing that he was dying and we were going to miss him and that he would not be there, and especially one of the things that hurt me so much was that Kenneth nor my father-in-law would be there to share my sons' life. That my son wouldn't have memories of them and they wouldn't be participants in helping us to raise him. When I say "us" I mean the whole family, because in my family we are so close that everybody adds a little bit to the ways of everyone else in the family. I think one of things I realized too in watching the different ways the people in the family reacted to Kenny's death, my brother who went to the hospital and saw Kenneth's' body while he was still warm and blood was still pulsing, he sort of shut down. He didn't want to see Kenneth in the casket and he didn't. Even at the funeral, when they still had the casket open, he just walked by because he said he didn't want to see Kenneth after the undertaker had done whatever he had done to him, because that image of him lying on the stretcher, still bleeding, was so vivid, and he was hurting so much he didn't want to see him again. My Mom was grieving very

heavily and at the funeral she kissed him while he was in the casket. My sister, who is afraid of dead people, afraid of cemeteries, and has a hard time showing love and affection, she was so overcome with her emotions at the funeral she had to be taken out. Just seeing the different ways that people in the family were responding to his death, it just enlightened me as to how people grieve so differently, and yet, while everyone was grieving differently, I noticed none of us was helping each other to grieve.

C: Did you not feel support from each other? Or was it like each one was an individual?

R: It was like each one was an individual, except when we were ganging up on one person. My Mom just kept talking about everything that happened.

C: Just kept repeating the scene?

R: Kept repeating all of the details of that night and at the time we didn't realize that was therapeutic for her. But my Mom needed to talk. We needed to be silent. So she was spending all this time constantly going over all the details and everything my brother did that week and the last time she saw him and what he said to her. And everytime she brought it up, it made us have to relive everything when we didn't want to. So we were concerned that my Mother was "cracking up" and so we got together and said something had to be done because she was really making us feel uncomfortable. So I called, I think it was Compassionate Friends, a support group for parents whose children have been murdered. I pretty much told them what my Mom had been doing and they assured me that she was doing

very well and to let her talk. That was enlightening to me too.

C: You learned things from this experience.

R: From this experience: that we were all handling it differently, which was so different from when my Grandmother died, because she had suffered for so long there was so much relief when she was dead.

C: It was not the shock?

R: Right and because I was also a child and I didn't see my parents continuously grieving, whereas with Kenny's death, we were all continuously grieving. Even my Father would have moments when he would just talk about Kenny and there would always be some regret in what he was saying. My older brother for a long time wouldn't talk about Kenny. I have this morbid habit of taking pictures of bodies in the casket and at first there was some anger that I had done that.

C: People were angry with you?

R: Yeah that I would do that because they just didn't think that was the right thing to do. But later everyone seemed to be really glad that I did it. I think even having the pictures was therapeutic for the whole family and my brother who hadn't even looked at Kenneth when he was in the casket. After awhile he was able to look at the pictures and I think, in a way, that helped everybody.

C: Some conclusions?

R: Well, some conclusions, but it was also basically putting on paper the last visual image we have of him. And I think it helped all of us eventually. Whereas before they always seemed to be angry.

C: Shortly after that did you recognize your call to the ministry?

R: Well, it was shortly after that, but I sometimes think it was when God spoke to me that week and kept telling me Kenny was going to die. I feel as though that was God's way of changing our relationship and how He spoke to me. Our relationship went from me sort of waiting to see how God was going to work things out and then knowing what the message was or praying and just believing it was going to happen, to God just giving me this sense of just knowing. When I got the call to the ministry, it was the same thing, that God wanted me to do something. But it took someone else to tell me that it was my being called to the ministry and now, even looking at the path that my ministry has taken, I sometimes wonder which came first: God's need to have me doing the kind of ministry I am doing or Kenneth's death and my reaction to it, giving God the idea that I would be good at this kind of ministry.

C: Why do we call, and I notice, I don't hear you say that as much as I did when you first took your unit of CPE, that you had a death ministry.

R: I used to call it a death ministry but now I don't see it that way. I see it more as a life ministry.

C: Ministry to those who grieve?

R: To those who are grieving, but not only to those who are grieving, but also to those who are living. I learned a lot from Kenny's death. Kenny died in October '89 and my father-in-law died, December 1990 and in between the two of them, I have more sympathy for my father-in-laws' death than I do for Kenny's. I am

sorry for Kenny because he died so young and my father-in-law was basically twice Kenny's age when he died. But my father-in-law died with some dreams unfulfilled.

C: How many, do you remember now, how many funerals you have attended?

R: Oh gosh I have no idea. I have no idea.

C: Even though you have been doing this now for three years?

R: About three years. I think when I really started ministering to families who were grieving was when I did volunteer work at the V.A. Hospice and I did that I think about eight months. Basically I ministered to people who were grieving while their loved ones were dying and to those who were dying. One of the things I learned then was that people who are dying they really don't want to talk about dying.

C: They want to remember the living.

R: They want to remember the living. Most of the time I spent with patients who were able to talk and even with family members when the patient may not have been able to talk and the family members were sitting with them. No one wanted to talk about dying—they all wanted to talk about the greatest moments in that person's life. The person who was dying wanted to tell me about their travels, their hobbies, this was at the V. A. so they were all male patients. They talked about the girlfriends they have had, friends they have had in their lives. Family members wanted to talk about what a wonderful person, and maybe not such a wonderful person, that their loved one was. But nobody wanted to talk about

dying. They all wanted to talk about the greatest moments of living.

C: Living and the people that are important to them.

R: And the people who are important. There are even some instances where there were fathers, who for different reasons had alienated themselves from their families, and they were given a second chance, even though they were dying. They were being reunited with children.

C: So there is a healing process that was going on in some of the deaths that you have attended. That has been slow and coming for your family, as a whole, as a result of Kenny's death.

R: I think my family has, I think we have healed from Kenny's death, but the pain never goes away. I think we will all carry a lot of anger because he was killed and didn't die of natural causes.

C: Did they find out who killed him?

R: They knew the same night.

C: Was the person . . .?

R: He was arrested the next day. He was found guilty and he was supposed to serve about eight years, but he only served three or four. He was released.

C: Is the family angry at that short period of time?

R: We were, but after awhile we weren't. I even went through the whole thing at some point of wanting him to be dead—not necessarily killed, but it's like, you took a life from us, and it isn't fair that you have your life. Then we went through the whole thing of hoping everyday Kenny would haunt him, just all those mean

and hateful things you go through when you really want revenge. I think after awhile it didn't matter what happened to him or what didn't happen. Kenny was gone. The other side to that, we all had to admit, even if reluctantly, Kenny sort of set the stage for how he died. He made his choices. So, as angry as we may have been with the person who killed him, we all had a little anger with Kenny and that brought some guilt. It is a lot different when the person who dies was an innocent bystander, compared to a person who made choices to be in that kind of situation for the possibilities for death are great.

C: So he was in harms way.

R: He was in harms way. The other thing too, as weird as it sounds, but we have to really be grateful to God that Kenny lived for 29 years, almost 30. We go to the cemetery and we see graves of people who died at 18, 20, 22 years old and we are just grateful that we had Kenny for 29 years, because it could have been a lot shorter than that.

C: The difference between the passive victim and I think you were with a woman whose daughter was murdered in the home and they shot her hand off. That felt so surreal to me. When I visited her, it was like, "Oh the Lord is just going to bring me through. All things work together for good of those who love the Lord." She was spouting God-talk and really experiencing the tragedy put upon her family. Only a couple of weeks later she comes back in for a suicide attempt.

R: I remember.

C: Mmmhmmm.

R: I went in to minister to her and it was a very spiritual time. At that time, she even felt that God had spared her for some reason because she said they turned the gun on her and pulled the trigger and it didn't shoot. It was at her head.

C: Mmmm.

R: She also recognized something and I just felt as though that was one of the things that she was going to do for black people. She acknowledged then and there that she was going to need psychiatric help to get through her ordeal. As you know, black people do not like to get psychiatric help.

C: That was such a tremendous lost in addition to losing her hand. I was looking through the charts and there they were, the pictures of her hand.

R: I know. I was not expecting that. I saw them afterwards when I was going to make a pastoral note. And they just shocked me.

C: Her husband, or the girl's father, had not been told until the next day. He was someplace else or at work and they were separated. When he finally got to the hospital, he wanted to see her. I attempted to assist and locate where the body was, but it was not in our morgue but over at the medical examiners. Contrary to common belief, the medical examiners' office was very, very nice. One of the pathologists got on the phone to just inform him that he had just completed the examination and that the funeral home could come and pick her up. And that he could go over to the funeral home to see her. He could have given that message to the secretary, since he was the person who actually handled her case. Instead, he spoke with her father personally and it helped comfort him. He seemed

to be trying to manage getting his child buried and really just very hurt that her sister or whomever it was that had been allowed to live with them, had brought this mess into their lives and taken one of his children.

R: That was the mother's sister that caused it all. Well I don't want to say she caused it all but she was the one that they were looking for. She wasn't there and they just went off.

C: Where do you see this going, Rosalind?

R: I see it is definitely time for some changes. I think there are probably several issues that need addressing. Mainly there are a lot of people out there that have lost loved ones, but they are not receiving the grief support they need. Black people do not seek support like white people do. I know for a fact, of all the support I have gotten, and even with all the knowledge I have received, I still know what I am going through, just trying to deal with my brothers' death. I know I am probably far ahead of the average person of any race just because of my own work and my own knowledge. But there are a lot of people in the city of Richmond who are still heavily grieving over their loved ones and they are not getting the support they need. I also see a lot of young people who are headed for the same life my brother had and the young woman had. The homicide rate in Richmond is still growing and even though there are a lot of people and a lot of groups out there trying to reduce the homicide rate, the figures show that if it's working, it is going to be awhile before we can really see the results.

C: The repeaters are coming and some of the figures are showing three and four

times. I wish there was some intervention that could take place so they would not have to repeat. But it is still the anger and rage in their identity, their perceived identity, which mandates, that keeps them going.

R: Reverend Husband said something one Sunday when he was preaching and I believe it is true. It was in reference to a comment that someone made about the way the young black people are dying on city streets shows they are not afraid to die. Reverend Husband said maybe that was true, they weren't afraid to die, but more than anything, it shows that they are afraid to live.

C: Mmmmhmmm.

R: Because dying is easy. It's living that is so hard. I believe a lot of our young people do not want to live and it is easier for them to die.

C: So the other side of the homicide is the suicide, the sense of destroying themselves.

R: Yes.

C: Whether it is the drugs or whether it is putting yourself in jail or putting yourself in the path of someone that you have contentions with, you are choosing the weapon.

R: And basically when people choose, when people choose to use drugs, hard drugs, they are choosing to die.

C: You think they aren't getting killed over the money?

R: Well right now you hardly ever hear anything about marijuana. It's crack and cocaine and now heroine supposedly is on the rise again.

C: Oh, yes.

R: I think basically it's probably those drugs. I feel as though, especially with crack cocaine, because they say it is unlike any drug there has ever been, that people get addicted so much quicker. I think anyone who uses crack cocaine, even when they know the dangers, basically they are signing their own death warrant, because there are only three ways out: either in jail, which from all that I have heard about jail, you can get more drugs in jail than you can on the streets, so that's no guarantee that you'll get out; the second way is the cemetery, either by overdosing or someone kills you; and the third way out is some miracle happens and you turn your life around. It just doesn't seem like there are many people who are turning their lives around, compared to the number of people who end up in the other two places.

C: Okay. Thank you.

R: Thank you.

C: And I have found the ministry that you do, the contribution that you are making in the ministry, is encouraging. Keep it up. I want to see us moving forward.

"K.H."

Interview with K. H., a trauma emergency room nurse at the Medical College of Virginia Hospitals, with Chaplain Cecelia Williams.

CW: K, it's good to talk with you this evening. Thank you for taking the time for this interview. It will be part of my project as it relates to spiritual care for trauma patients. K, how long have you been a trauma nurse?

K: About 10 years.

CW: Have you been at MCV most of that time?

K: Yes.

CW: Over the past 10 years you must have seen a lot of changes. What have some of those changes been like?

K: Well, when I first came, I had a lot of patients who came in as a result of fist fights and stab wounds, a few gunshots with some of the smaller guns. Mostly, the people were adult males. Now, the patients are younger and younger, most under 30 years of age, mostly African-Americans and a few women. I would say 15 to 20 percent are women.

CW: How has the care of these patients changed?

K: Over the past few years, we have gotten much better, a lot faster, and, because of

technology, we can do more.

CW: What is the mission of the trauma ER?

K: The mission of the trauma ER is to provide immediate care to the patient, that we should get them to the operating room to stability and get them out of the emergency room.

CW: How do you rate the performance of this department?

K: I would say on a scale of 1-10, it's an eight.

CW: Do you see ways that it can be improved?

K: Yes. Sometimes, I think that without good reason people have to stay and wait in ER for many hours.

CW: Why do they have to wait?

K: Well, it's because some of the doctors are not here, and we have to wait for a specialist to come in, or we keep them down here until all of their orthopedic work is done. A lot of that could happen on the floor. Sometimes people are down here when they could have been sent to surgery. I believe that we could be better; that's why I said eight. Also, there are times when people are in too much pain. We do not get orders to do all that we can do for them to relieve them of their pain. Also, it would help if there was one director who orchestrated everything and would listen to the reports of the EMT's. That would give us more information to work with sooner. However, a lot has improved, but a lot still needs to be improved.

CW: People call this the miracle center. There seems to be an expectation that a lot of things can be fixed. How do you see that?

K: Well, when you're in the moment with the adrenalin flowing, there's a lot of excitement; but you don't really think about miracles or any of that. Everyone just concentrates on doing their job and doing it the best that they can, and it is rewarding to know that it does help.

CW: Do people let you know that they appreciate what you have done to help them?

K: Well, sometimes. Even if they don't say it, some people express appreciation, even if just by looking into your eyes which says "thanks." Families often express their appreciation. The rewards are not constant, and sometimes it's the other way around. There are expressions of violence and threats, and they cuss you.

CW: How do you deal with a person you're trying to take care of who cusses you out?

K: Well, I'm little, and I can't fight them, so I just tell them, "I'm not going to fight with you. I'll let security deal with you, and you need to cooperate." That usually works. Most people calm down and allow us to go on and take care of them. The police and MT's reports let us know what's going on and the possibility of retaliation. With these reports, we decide how the case is going to be handled with regards to visitors and our own security. More and more gunshots are what we are seeing. There seems to be no regard for human life. They seem not to have any fear for their lives, and if there is an intent to retaliate, they would not mind killing a nurse that was in the way. Fortunately, we have not

had what you would really call a violent incident in the hospital. But because of the type of patients we have, it could certainly happen here.

CW: What about the improved safety requirements?

K: Well, it's been a long time coming, and we still need more. We have to adjust our environment to the type of patients we have.

CW: What do you mean?

K: Most of our patients here are involved in violence, people who have been involved in crimes, and have little or no respect for life. They are younger and younger. Some are proud that they have been shot six times, and they show their scars with a lot of pride. There is no fear. They have engaged in this because they're trying to prove that they are tough. Their reputation is all they have. Deep down, it's very sad. They are saying, "I'm a man, and here are the scars to prove it." Deep down, I think that they are using a gun to resolve conflict. That is really the coward's way out.

CW: K, you were raised in Richmond. Why do you think violence here has escalated?

K: (After a long period of silence) Well...

CW: Why do you think violence here has escalated? Why so much despair?

K: (Again, silence) Well, people don't care anymore. They don't care. They learn some of this from the schools. Their families don't care. Some of the people who are coming in here, in fact, are patients, that don't have values and morals. These are things that I learned from the families. They just don't have it. They don't have a respect for life anymore.

CW: Do you see contributing factors to it?

K: Oh, yes. This city, like most cities, probably more than most. People who come here from other places said they've never seen anything like this. (I mean, the prejudice.) It's right at you. It's not hidden. Many do not want to admit it, but it's here. It exists on both sides, for both blacks and whites, and people do not want to change their minds.

CW: So racism is a part of it?

K: Yes, but that's not all. It's mostly the disrespect, how they think. They do not have it. Some do not have the choices. They are victims of circumstances, but they do not have to kill because of this.

CW: So, you would say the families make the difference?

K: The values set in the family, and that makes all the difference.

CW: How do you see the role of the chaplain in trauma ER?

K: The chaplains are very helpful. They help with the families. They provide information between the staff and the family, and they offer prayers. Some want a chaplain, others say they're not interested, but the chaplains are very helpful. Some chaplains are better than others. Some are very reserved, and others tend to stand back. Most are pretty good. Chaplains help to make things better. Occasionally, I can remember one occasion when it was very bad, and this chaplain learned.

CW: What happened?

K: Well, he gave a family the wrong information. He told them that their loved one was dead, and certainly, they did not know this. He didn't know that they didn't know. Rather than clearing with the staff to make sure, he just entered into a situation and gave them the information and needless to say, they fell apart; and a lot of things disintegrated. Also, in case you want to give the patient something they're not supposed to have, something like water or something when they ask for something like that; but mostly, chaplains are very helpful.

CW: Why did you decide to become a trauma nurse?

K: Well, I thought about being an EMT or a doctor, but I decided on nursing. I can say I kind of like the treatment and actually, the gory stuff, and so this provides that kind of experience. I never really thought it would be like it is. I must say I've enjoyed it, and I really did like working with the people, and I like feeling that I've done something to make a difference.

CW: Okay, thank you very much for your time and for what you do here with our patients. Thank you.

The Reverend Kenneth Dennis

Interview with the Reverend Kenneth Dennis, a Chaplain with the Richmond Police Department, who has been very active in the Richmond community and a leader in this community for the past eight years. Reverend Dennis is the pastor of the Greater Mount Moriah Missionary Baptist Church, located on Second Street in Richmond, Virginia, which is known as "the Cathedral in the community."

(CW = Cecelia Williams, Rev. = Reverend Dennis; Dea = Deacon Thomas Green)

CW: Reverend Dennis, why is there so much violence in this community?

Rev. Well, the violence has arisen in this community because of a similar situation that we find in the book of Judges 21:25, "In those days there was no king in Israel; every man did that which was right in his own eyes." There arose a generation that knew not the Lord of hosts. This community's direction began to move in an opposite direction from the upwardly mobile middle class family community in the late seventies. In the past 25 years, culture shifted to a philosophy of, "It's your thing, do what you want to do."

After veterans returned home from the Vietnam War, it appears that they, along with others in that same age group, seemed to be lacking the values of the

earlier generation. Many experienced Post-Traumatic Stress Syndrome after the violence they experienced and witnessed in the war. The values that occurred in the community changed. Those who stayed at home had no respect for their country. There was a disregard for authority, and there was a breakdown of the family. Mothers are heads of the households alone. There is a definite absence of adult males in the homes. Mothers traditionally love their sons and raise their daughters. Daughters are taught to take responsibility, while sons are catered to and set up like little kings. Repeatedly we see mothers getting sons out of jail.

The welfare system has served to contribute to the breakdown of family, particularly through the Welfare system. That demanded support could not be obtained as long as fathers lived in the home. This has led to a generation without dads. The idea is often communicated by women about the man, "That's just my baby's daddy." There are little expectations of the males. In the movie, "Claudine," in the 70s, there was a scene that showed the male as irresponsible. In fact, Claudine was fearful to get married because she did not believe that any man could be responsible. With the rise in Welfare and dependence upon outsiders, the family has experienced all but total destruction.

The housing project, like Gilpin Court, and other housing projects in the city, were areas that were neglected by government until it was totally dilapidated, in this way, on 40 acres, Gilpin Court was built. Children see all kinds of violence regularly in this neighborhood. In the Old Testament, the priests were the providers for the family. There is an absence of priest leaders in

this community. In fact, we see what has moved from the leadership of the priest to what I call "church pimps."

There is a rise in the negative influence in this culture. Again, I want to reflect back on whom this God is that they do not know. The true God is the provider; it is God that provides for our needs. This community has lost protection. In mothers' overprotection of the sons and daughters' teenage pregnancies, we now have a system that is a re-enactment of some phases of slavery. I am reminded of the term that came out of the movie, "Superfly," that says "statutory purple." What we find in this community are young girls being pimped by old men. Again this further erodes the family.

There is psychological castration of the black male and rape of the female. Black men no longer hang on trees like during the lynchings of the 30s and 40s. Instead, we find they have taken the role of killing each other.

Again, as art imitates culture in the movie, "The Godfather," drugs are prohibited from being sold in upper class white communities. They were instructed by the godfather to allow the drugs to be dumped into the black community. Laws that are currently on the books show a disparity in the punishment for cocaine. The difference between powdered cocaine and crack cocaine has led to high numbers of incarcerations of black males. This loss further erodes the family. When the men are in jail you stop producing and the community dies. Contrary to what many people believe, the seed of the nation is found in the men. If men are killed, it will end the nation. When a young man is

arrested, you have to fall back on the women. A young man has to call his mother to try to get him out of jail, and she does all she can to bail him out. Then, a young white female attorney shows up to represent him. Again, it's women power—women power all over again.

CW: What is the role of the church?

Rev.: Well, men need to be welcomed back into the church. The Bible does present several passages that appear to be oppressive to women. The true leadership of a man will provide leadership in the home and community. Most black Christians, and I hate to say this, are somewhat schizophrenic. They believe in a white Jesus and see that as "the Man." This is a distorted concept of religion. Islamic growth can be attributed to some of the oppression you see in the church and the absence of the male because the Islamic approach to young men is that they need to be connected to other men so that they can learn how to be a man. This could not happen in a black church with a white God.

CW: Than again, let me ask, what about the role of the church in what's going on in the community?

Rev: Carl Marx said that religion is the opium of the people. Opium is a drug. This is the way that we see many of our churches, anesthetized on religion. There is a theology of "don't." The other extreme is a lot of emotionalism. For instance, you see a high incidence of teenage pregnancy in religious denominations that are highly emotional. The church shows the other side of rage in its expressions of shouting. Rage has several expressions. One is an expression of sex and fighting.

The music that you hear now communicates negative messages. The rappers, Little Kim and Biggie Small, are preoccupied with sex, violence, and guns. To young men, the gun represents authority and the way that they receive respect. More care is given to the gun than anything else. Young women see themselves as valued because of their sexuality. (At this point in the interview, Deacon Green is invited in.)

There is a technical part of what is happening in the murders. One is the speed loading which creates multiple gunshot injuries in seconds, instant mutilation. Thomas Green is a former Deputy Sheriff and in charge of Outreach. (He demonstrates with his weapon how quickly 14 bullets can be shot and reloaded. I am amazed at seeing this done.) It's violence and what it will do. Dr. Garvin of MCV trauma center, who directed that department for many years, attributes many of the deaths to new types of weapons. (Deacon Green demonstrates how weapons have become more efficient.) Some of the guns that are on the streets can be quickly loaded and reloaded. The drive-by shootings kill our youth.

Today in this church we buried two young men. I believe funerals are important because they confront youth directly with death. When they see their friend lying dead, that says more to them than what any of us can say from the pulpit. We believe that we have to be living representatives of God in the community. Therefore, this church pays for many funerals. Today in the funeral, this person was given dignity and the family felt the support of the entire

community. We are also involved not only in funerals, but other community activities, such as Community Day at the park. Deacon Thomas is involved in going to the schools to reach out to kids in the elementary schools and to take them on outings. Deacon Thomas also accompanies the youth when they are baptized. Baptism is becoming a significant rite of passage. After children have completed a significant course of Bible study, they are baptized and connected with the Sunday school. This is a place where they also invite their friends to come.

CW: Deacon Thomas, what motivates you to do this?

Deac: Well, I am not sure. I just felt God was calling me to this. I know the streets well, but a few years ago I was required to retire from the Sheriff's department after a heart attack. My mother also had a heart attack. These were real wake-up calls, and I experienced God's grace. In fact, I can say I am a testimony. Therefore, I want to do something in the community. I believe in trying to help educate the community as to what is going on.

Rev: Mount Moriah is a community church and it heads several ministries. It has the Hope in Healing ministry for HIV and AIDS patients which also involves prevention, congregational care team. The church welcomes individuals with alternative lifestyles who need to be a part of the church. I want it to be known that these individuals are embraced by the leadership. We want the wounded up front. We also have drill teams in the public schools. In the Shocal Hills area and the Faye Towers housing development and detention center at the Barrett

Learning Center, many of us healers are wounded healers. On Tuesday nights at 6:30 p.m., the survivors of homicides meet. Many of these survivors have gone on to be participants in the business of healing. We feel God's power here.

CW: Reverend Dennis, how is God's power accessed?

Rev: Well, it is in the message, the word, the message of hope. Our ministry is to the broken. God honors faith and our history teaches us to trust God.

CW: How do you access this personal power for the empowering of the community?

Rev: It is in allowing people to perform what they see God is calling them to.

(Reverend Dennis at this point calls in another young man who is involved in ministry to AIDS patients and is conducting AIDS education in the community.)

CW: Reverend Dennis, I certainly thank you for your time and for your perspective on what's going on. I know that we're much aware of this area and the part of the police department. We see you a lot at MCV. Thank you very much.

SUMMARY

This chapter consists of five interviews with both professionals and survivors of violence. Their personal experiences provide us with insight into how the present situation of violence was created. Years of abandonment and neglect have created an environment of lawlessness and violence that is now found in many African-American communities.

Richmond, like many large urban cities, has a high crime rate. It's unique for a city this small to have such a high percentage of crime. These interviews tell the story of the community that once was a place that thrived because the soul of the community was intact. People worked and celebrated together. There was a sense of wholeness that marked the way people loved and cared for each other.

In those days, family and especially the children, were valued as the hope of the future. Therefore, education was highly valued, even in small segregated schools. Children were seen as persons of value by adults that constantly affirmed their dreams and aspirations and gave them the opportunity to demonstrate their gifts. Music and drama were a part of the ongoing celebration of life. Discipline and order reflected that they respected themselves and each other. People believed that God would provide for all of their needs. People shared with each other and many of their needs were met within the community. People usually shopped in their own community and the merchants lived there also. The same is true for professionals. They were not outsiders

who were there on a benevolent mission, nor did they just come into the community to use it as an object for their own education. Teachers were major contributors to transferring values and requiring excellence in education. The results of school desegregation for the most part did not enhance the values taught in schools, it brought in external authority which did not value the culture.

After integration, in the mid-sixties, teachers tried to adopt values of the white majority. Many teachers and administrators abandoned or neglected their own traditions. The changes were slow and subtle, but this was a significant loss of values that was devastating. The abandonment of traditional African-American values were replaced with "upward mobility" that was understood through materialism. The trend toward dishonoring was subtle, children were no longer seen as an investment in the future, but as a nuisance or troublemaker. This was especially true for boys.

When opportunities to move into better communities became possible, it caused an absence of responsible leadership. Many successful individuals left the inner city, leaving vacant the place of leadership and protection that they once held. Without the protection of experienced leaders and respected elders, systems and institutions that protected and educated the community were left handicapped. The community's hope for a better tomorrow through integration put too much hope for what it would achieve without honoring and valuing what the community already possessed.

Since Richmond's involvement by African-Americans in the Civil Rights Movement was passive, youth did not feel they had power. The absence of strong male leadership, along with the growth of the drug culture, combined with many other factors

have produced a community of lawlessness. Respect is a repeated theme.

Churches were virtually unaffected by the changes brought about by desegregation, with these exceptions, most of the members live outside of the community where the church is located. The power that the church once had to influence change has eroded over the past 35 years. Their prophetic role that once confronted systems and spoke truth to power, is silent. They no longer see the community-at-large as their parish and act as a seer for the whole community. These days the mission of the church has become internally focused. Very few churches see their role to educate, care, and protect the whole community. Even with this shift in their pro-activity, they are the only ones that have the collective attention of thousands of persons on a consistent basis. The church is one of the remaining institutions that is able to heal this "broken village."

The interviews with the survivors of violence are the real heroes and heroines. They exhibit extraordinary courage in the face of tragic situations. Losses, like the ones that the two women encountered, express deep pain and sadness. In these interviews they allow their grief to be seen and felt by the reader and myself. I appreciate them sharing their intimate reactions. The transformation that they have undergone and the substance work for healing and prevention is truly a miracle.

The interview with a trauma nurse offers a first-hand account of the motivation and the dynamics of a busy state-of-the-arts medical treatment center, yet the feeling of committed caring staff for hurting, victimized human beings still exists.

CHAPTER SIX

SPIRITUAL AUTOBIOGRAPHY AND PERSONAL HISTORY OF REVEREND CECELIA ANNETTE WILLIAMS

I am a fifty-four-year-old, African-American woman. I am employed by the Medical College of Virginia Hospitals/Virginia Commonwealth University as Assistant Professor in the Program of Patient Counseling. In my role at the university, I am primarily a clinical pastoral education supervisor, responsible for pastoral formation and clinical supervision of students. I also participate with faculty administration and curriculum development. I serve as chaplain to one of the nursing units, Main-9-Central, which is a medical-surgical floor. Many of the trauma victims that come to our center receive care on this floor, particularly those who have received intentional injuries, i.e., gunshots or stabbings. In addition, a variety of other medical conditions are found there.

I am a mother. My oldest child, my son, Randolph, is thirty-five years old. Randy works in the construction field. He has two children, Angelica, age 10, and Randy, age 8. His two children currently reside with me, as I have legal custody of them. My daughter, Tina, is thirty-four years old. She resides in Hartford, Connecticut, and is a newspaper reporter. Her work is the love of her life and she is meeting with a great deal of success. My daughter, Deia, is the youngest. She is twenty-three years old and works

in the Security Department of the Medical College of Virginia. Deia has a separate address, but she is constantly in my home also.

I am an ordained elder in the African Methodist Episcopal Church. I was ordained in 1981 under the hand of Bishop Frank Curtis Cummings. Since that time, I have served several congregations and am now in my fifth appointment to a small church in Harrisonburg, Virginia. I am the widow of the Reverend Volover Williams, who died May 2, 1997. I have lived in Richmond, Virginia for the past five years where I serve on the faculty of the Medical College of Virginia.

The method which I have selected to tell my story is within a developmental framework that reflects the work of Eric Erickson, James Fowler, Robert Keen, and the works of Myron Madden, particularly his book, *The Power to Bless*. My understanding of my own story has been a source of enrichment and empowerment. It has allowed me to look at my own journey and to embrace the reality of the presence of God. This has been a transforming experience.

Birth and Early Childhood

My story begins with my birth in Columbus, Ohio in 1941. I was born in the midst of struggle. My mother was not married. My maternal grandparents lived in Lima, Ohio, at that time. My grandfather was a pastor. Of course, this presented some level of a crisis in their family. In those years, it was not appropriate for one to give birth out of wedlock. Therefore, my mother was sent to a home for unwed mothers in Columbus,

Ohio, and that is why my birth took place in Columbus. The plan was that I was to be placed for adoption. After my birth, my mother contacted her father and asked if her parents, my grandparents, would accept the responsibility of rearing me. They agreed, and three weeks after my birth, I went to Lima to be reared by my maternal grandparents, the Reverend Hiram and Eva Maddox.

My reflection on these early years is that it was a time of confusion, uncertainty, and fragility. It raised a question of whether I was accepted. Through therapy and pastoral care, I have learned that God has placed within me a spirit of survival. Somehow in the midst of the confusion of whether I was wanted prior to birth, I became a survivor, and that, when all else is removed, I am indeed a child of God. My understanding of how my developmental process occurred continues to be a rich fountain of growth for me and a continued embrace of trust in God and God's faithfulness. Metaphorically, I see my life to be a fabric which started out as a very thin, very weak strand, and through experiences, developed basic characteristics which have been my strength. There have been places that seemed to be woven very loosely. In fact, there have been places that have been ripped up and re-woven.

My ministry with others has helped me to explore my own life and both the power and limitations of the pain of my early days. I am aware of the impact of the abandonment that I experienced, yet I am also aware of the paradox of the grace of God that allowed me to be reared in a home that was indeed a training ground for the ministry that God was preparing me for. Because my grandfather was a bi-vocational minister, meaning that he was a pastor who had a contracting business and served several

churches, we were required to move often. In fact, I attended six different elementary schools. As a child, I remember feeling hurt and confused as I had to enter new schools and look for a way of being accepted. At times I found it very hard to try to explain why I was not raised by my biological parents as many of the other children were. Not having biological parents created in me a sense of inferiority. It was not possible for me to have a clear place for expressing this sense of inferiority. However, I remember that I did have a very unique sensitivity to the feelings of others and a keen barometer of what was going in my environment. For this, I was affirmed.

I was reared with my cousin, Gloria, who is twenty days my junior. We are very close. There was always a sense of rivalry between us. There was, however, little contest that she had the affection of both of my grandparents. I was quite willing for her to have that, somehow recognizing and believing her to be more worthy than I. Ours was a devout Christian home in which the Christian code was the law. Love was expressed through care and duty, with very little affection. Discipline was swift and sure. I learned a sense of dignity, pride, and hard work, which have been my constant companions.

Adolescence

There were three crises, indeed traumas, that I experienced in my late childhood and early adolescence, which have had a tremendous impact upon me and allowed me to see the drama and impact of God's sustaining and healing power. When I was thirteen years old, my grandmother became ill and was diagnosed with uterine cancer. She was

treated with radium, which in those days had not been well developed. This caused, not a cure for the cancer, but in fact, burns to a section of her bowels. We watched this woman, who had always been overweight, diminish and become thin and frail and weak. Our life in the home changed from my grandmother being the chief caretaker, to each member of the family caring for her. I saw both the church family being very supportive of the family and all of us being very frightened. Because of my grandparents' belief in divine healing, even the treatment was somewhat suspect if that should have been done. However, we always believed that God would heal. In fact, while she was awaiting surgery for a colostomy, the miraculous took place. We were waiting and praying in church for her healing when she reported that she, who had not had a normal bowel movement for weeks, did, in fact, have a normal bowel movement. The doctors were amazed. Needless to say, the surgery did not occur. Her body's own healing process went to work and she was healed. We came back home and life went on.

My grandfather's accident followed shortly thereafter. He was a very unique person, a vivacious personality, open and very extended outside of the home. In the home, he was more introverted and a student of scripture and the word. In his work as a contractor, he was working on a church and was hammering above his head with a hatchet. The head of the hatchet flew off the handle and split his eyeball. Because of his belief in divine healing, he did not seek medical attention, but provided himself with the self-care of a ritual of daily washing out his eye and proclaiming that God was going to heal.

His son, my Uncle Clyde, decided that things had gone far enough after several weeks passed and his condition deteriorated. He nearly forcibly took him to receive medical care. The surgeon examined his eye and decided it would need to be surgically removed immediately. My grandfather prevailed upon the doctors to allow him to return home and instructed my grandmother to call "the saints together." She did. A group came together in the living room of our home. These were folks who believed in faith healing. They prayed for one hour and dismissed themselves.

It seemed to be a real crisis this time. I thought certainly he would be blind, as the doctors had said for he had decided that he would not have the surgery. Since the doctors had said that the poison from one eye would take the sight from the other, he would be totally blind and in outrageous pain. The loss of his sight, for me at that time, seemed to be a certainty. But, he continued his ritual of rinsing his eye several times a day. His position was very unpopular among church members. People began to whisper and wonder if he had not only lost his vision, but had lost his mind. Their cynical and uncaring viciousness showed me, at a very early age, how uncaring the church can be for those who are its caregivers and what it means to take an unpopular stand because of one's beliefs.

The truth is that his eye did heal and he did not lose his sight in the other eye. While his vision was not absolutely clear in the injured eye, it was better than the expected diagnosis. This, indeed, was a miracle. Again, we saw God's hand moving and supporting.

Almost simultaneous to this occurrence, the church began its vicious rumors and accused him of having a romantic affair with a woman. The rumor was proven invalid, but the damage was done. A man whom I had never seen really express anger directly, internally grieved. The decision was made that he would leave that church. He went on to another church, but somehow was permanently damaged by this event, yet, in his own way rising above it, trusting a God who not only was his healer, but would support his faith. I witnessed these events and recognized how hurtful the church could be.

Being a sensitive child, I was impacted both positively and negatively by what was happening. I wondered about God's activities; how and why did God work? I believed because of the miracles that I had seen, but I was confused because of the meanness that I also saw from the so-called people of God. I did not want to live or be too close to a church when I got grown, because I did not want to have my own family experience the kind of pain we experienced. Because I believed it was not possible for me to discuss the traumas that I was experiencing with the family during that two-year period, I felt it coming out in my school work. It became more difficult for me. Teachers wondered what was wrong, that I did not comprehend well, when in fact the truth of the matter was that I was experiencing the emotional stress from the family.

I entered junior high school and, for some reason, began to feel more accepted and very much a part of the community and family. However, things in our world, our community, and city were changing. In Cleveland, Ohio, a Northern city, our school had been somewhat of a "melting pot" with many cultures represented within a classroom. As I began to explore what life would be like both in high school and afterward, I

became aware of differences that were made between black and white children. Also, when I was in the ninth grade, I was offered the opportunity to go to a girls' school to learn a trade. Jane Adams seemed like an attractive school that was marketed as a place that taught fashion design and other exciting careers. I enrolled there. This was a very important decision that involved leaving the friends whom I had gotten to know very well and my community to travel across town. It seemed like a professional opportunity, and since college was not on the horizon (my grandparents had not been college-educated, nor did they value that), it seemed to me that it would be one of the better ways for me to be able to develop a career.

After entering Jane Adams and receiving their counseling, it was not long before I realized that the school was not designed for a "colored girl." They did not want to train someone for the fashion industry whom they would not be able to place in a job, since black women did not have a place in fashion design. The opportunities were limited. Therefore, I was introduced to power sewing. It took me all of three weeks to operate every machine they had. By the time I was in the eleventh grade, I decided that it was just foolishness to continue to get an education that covered just the basic curriculum and did not add the professionalism that I had desired. If I was going to run power sewing machines, it would not be for a school with a contract for another company. I could go out and become employed. Which I did.

I went to Bobby Brooks, got a job, worked a half-day and went to school the rest. My education did not meet all of my expectations, and I was disappointed. As I neared the end of high school, suddenly my grandfather died and our life again was placed in a

spin. Grief, hard work, and uncertainty became a part of my existence.

Early Adulthood

In the late 50s and early 60s, in the City of Cleveland where I grew up, the social climate was changing. Although blacks in the city had a long history of civic and social involvement, there was a struggle for inclusion in government and in more of the economic life of the city. Integration for lunch counters and such was the same as it was in other cities. While schools had been integrated, there was a *de facto* factor that was segregation based upon neighborhoods. I lived in an integrated neighborhood and had not felt its full impact in school.

My feelings around personal identity and the struggle for, as it was called in those days, integration, were confusing. It felt much like the question that had always loomed over me in childhood—was I accepted? From my reflections, I learned that I had to be involved at some level in this struggle that was going on in society. How, was not known. I had tried to be involved in some picketing and my grandparents would not allow that. Now, as an adult, other opportunities of being involved presented themselves.

During this period, I was on a personal pilgrimage of reading and understanding life and what had gone on historically from my own understanding, not within the limitations of "black history" that the school had given, which was so limited that it raised questions in my mind—how were the atrocities and indignities of slavery even possible? and how was such abuse possible? and, in fact, I did blame the victims rather

than seeing it for the hideous thing that it was. My reading informed me. I learned from reading writers such as Lerone Bennett, Jr., John Hope Franklin, Benjamin Quarles, W. E. DuBois, Billingsley and the Reverend Dr. Martin Luther King, Jr. and others that our history was filled with heroes and should be a source of pride. I, as a young adult, began to attend lectures where I heard persons of power speak about what was going on in these critical times. They challenged us to look for the future.

I believed that government offered solutions. I, therefore, worked in several political campaigns. The events that took place in my early adult years caused a disquieting and a longing in me to participate in changing things, but I did not really know exactly how I was going to function in the community to lead it to a betterment. However, I felt a need and a desire to do that.

I learned about, and appreciated in those years, the theater. Karumu House was a part of the Cleveland scene, and many of the members of a professional theater company were trained there. Through the subtleties of the theater, I could see again the uncovering of what the insidious racism in our society had done. Almost at the same time, I began to learn about a different music—music that we were not really permitted to play when I was child—jazz and blues. I was absolutely fascinated. It seemed to strike chords in my soul that allowed a piece of me to run free. I can remember hearing for the first time music by Ellington, in such works as "The Drum is a Woman" and, of course, Sarah Vaughan, Aretha Franklin and many other such works of art, that touched my very being. Listening to them seemed to transport me to another time, another place, both from the past and to the future. Oh, was it invigorating! I still love jazz, blues, as

well as gospel music.

I joined the Baptist church, both as an act of differentiating from my family and rebelling. I wanted to be a part of a large, influential church. I was in fact, again, disillusioned in the church. This was a different kind of disillusionment. I saw what I considered lifestyle conflicts—people did anything. They had parties and all sorts of things I considered immoral were taking place in that church. I still stayed with the church.

I was married when I was nineteen years old and divorced eighteen months later after a stormy, abusive marriage, and the births of my first two children. They were born during what seemed to be the darkest days of my life. I wondered if I would ever escape from the hell I had entered. When my first son, Randy, was born very prematurely (I carried him only twenty-six weeks), it was a crisis. I saw doctors working frantically to save his life. Through the grace of God and much prayer, this tiny, frail child began to grow.

When he was three months old, we finally brought him home from the hospital. A year and one day later, Tina was born, again prematurely. Being premature (about one month) raised the issue of her survival. The doctor and I argued in the delivery room to try to get him to help her. He did not. He made a disparaging remark that, "Who knows if she's living or dead?" and that they were more concerned about me. A black nurse stepped to the scene and picked this child up, thumped her and suctioned her and got her going, thanks be to God! I felt alone. I felt abandoned. My husband did not even come to the hospital for the births of these children. Yet, I was able to make a new vow and a

new covenant that I would always be there for my children. I would never abandon them or put them off to be raised with anyone else. It was God's grace that saw me through that time.

After struggling with a divorce by the time I was twenty-one years old and with two children to support, my strong sense of survival and the work ethic propelled me to the work world. For several years, I worked at low-paying jobs, seeking to support myself and the children. I realized that my best efforts were inadequate to meet the economic needs that I had. Finally, I swallowed my pride and accepted a program that was sponsored by the welfare department, Aid to Dependent Children. The department had an education opportunity program which allowed mothers to send their children to a good day care and mothers could go to school. That was my chance, and believe me, I took it!

I attended a community college and learned some secretarial skills and after the election of Carl B. Stokes was able to get a job in a community service center. That job was the beginning of a career path. I worked in the Kinsman Opportunity Center and I felt like I was arriving! Working in the poverty program, I worked with other welfare mothers and organized a self-help group, buying clubs, and tenant organizations, participated in fund-raising and day camps—I just ran around!

Finally, I came to the attention of Myrtis Taylor, the director of the community service center, who appreciated my enthusiasm and work in the community. She offered me a job. I deeply respected Myrtis Taylor and had, since my childhood. I saw her as a pillar of our community. She gave me plenty of opportunities. I worked as a community

organizer doing all kinds of things, including serving as a mentor to students from Case Western Reserve who were assigned to me to work in the field in a poverty area. Well, I did not have a degree, but I had learned how to be a community organizer and I was a part of their field training.

During that period of time, I met someone who was very interesting to me—a Baptist preacher—the Reverend DeForest Brown, Jr., who worked in community economic development in the Hough area of Cleveland. DeForest and I fell in love and had a fair marriage for many years. However, I always understood that marriage was not the priority for him, that his work in the community was. For the fifteen years we were married, mostly I was willing to compromise the lack of intimacy, because I was so much in love. Finally, that turned out not to be enough for either of us and the marriage began to die.

My daughter, Deia, was the gift of that marriage, although her birth was another time of crisis. During delivery, my doctors discovered that I had fibroid tumors, which made it impossible for them to separate the placenta, thereby requiring emergency surgery to stop the hemorrhaging. During the hemorrhaging, I coded several times and it was in fact a near-death experience. That experience allowed me to come away a fuller, richer person. With all the miracles that I had ever seen, this was the most meaningful to me. God had allowed me to look over and, yet, gave me the full assurance that I wasn't going anywhere, because the work that He had for me had just begun. Once again, I had fallen into God's hands, and God decided that I would survive.

Call to Ministry

We moved from Cleveland to Washington, D.C., and on from Washington to Massachusetts. It was in Massachusetts that I found St. Paul African Methodist Episcopal Church in Cambridge, under the dynamic leadership of the Reverend John R. Bryant. St. Paul was an active church in spiritual and social development. It was there I came again to grips with a call that I had heard earlier, when I was sixteen years old and did not want to accept. Now I could no longer escape from the call, because it seemed to me that if I would say no to God with the full knowledge of where I had been, I would fall into the hands of an angry God, having nowhere else to go. It was in the midst of marital conflict that I was able to clarify my call to preach.

With much anxiety, I announced my call to our then pastor, the Reverend John Brandon. I was given a message. The drama of the call was assurance to me that there was no doubt of what God had for me to do. My alternative was to go to law school. I was a student at the University of Massachusetts and worked for the attorney general. The ministry's call seemed like a new conversion experience. I felt the depth of my spirituality renewed. I felt again accepted and relieved from unrealistic guilt and shame. I felt whole for the first time in my life! I moved to a brand new spiritual level.

It was during this time that I completed my undergraduate work from the University of Massachusetts, to the credit of Phyllis Freeman, my advisor at the School of Community and Public Service. It was with her help in College III, which is a

competency-based educational program for adults (which meant pass or fail), that I was able to matriculate through the curriculum. I was thrilled, oh, was I thrilled to receive a B.A. degree! It seemed to me that, after all those years of feeling inadequate, after years of being told that I wasn't quite smart enough, that finally I had a degree—something that many others in my own family did not have.

Being employed by the state attorney general in the Civil Rights and Consumer Protection Divisions, I had many opportunities for engaging with the community and fighting many of the community fights. I was enjoying being at St. Paul's, working for the attorney general, excited about going to Andover-Newton Theological Seminary, when all of a sudden, DeForrest told me that he was not going to stay in Massachusetts. He was quitting his job and if he took another job it wasn't going to be there.

So, he did take another job--in Louisiana. Therefore, I tagged along and did not go to Andover-Newton, but in fact to the New Orleans Baptist Theological Seminary. Our marriage did not last, but something new had been born. I came into a ministry and learned more of God's grace. I learned that I could depend upon a God who would not abandon me.

Ministry

In 1981, I was ordained as an elder in the African Methodist Episcopal Church. Upon moving to New Orleans, I had asked Bishop Cummings if he would give me a "John Wellsley appointment," which is to start a new work. I started a church in1979,

first holding Bible studies in my home. Later it grew into a congregation and after three years, we were a congregation of about seventy-five. I had the opportunity to purchase a church with several acres of land and I did. The Lord was blessing the work and I felt at home. I felt accepted as a part of my community, growing and thriving, when (does it ever cease?), without warning, upon going to the annual conference, Bishop Cummings moved me from my church! Oh, did I feel angry and hurt! It was abrupt. It was surprising. I was angry and confused. The church members remarked that the sitiuation was like a forced divorce. However, this was not my only option. Life had taught me to keep my options open.

I had already entered clinical pastoral education at Southern Baptist Hospital, where I had been accepted for a resident year. In my first and second units of training, before taking Advanced, my supervisor and I had begun the discussions about my training to be a CPE supervisor. While I didn't understand all that it meant, I recognized that CPE had been a place that had been life-changing for me. I had a ministry and I was developing myself as a caregiver. At the same time, many of the wounds of the past that I had always carried were being healed. In fact, I was learning the power to not only bless, but to be blessed.

It was from my supervisor, Dr. Myron Madden, that I began to really internalize and learn of my own self-worth. It was from my supervisor, Bob Pearce, that I learned to creatively confront. Bob always affirmed that I had a great deal of compassion. The skills on how to develop theory and practice, I learned from the Reverend Gene Huffstettler. These three are all Southern Baptist ministers, but somehow God brought

our paths together. I learned a craft and God blessed me in this field. The students that I have learned from through the years have been a tremendous blessing to me. I have learned how to share and to give of myself.

One of the things I know about my own theory and practice is that it takes into account the "story," the psychology of the phenomenological. The "story" allows me to embrace every thread of the weave that is in my motif and my way of being—how my patterns of survival have both helped and hindered. What options have I to be a vessel to God? This has been a healing journey. I have entered the lives of those who have been broken as patients. I have also entered the lives and the pilgrimages of students who are persons developing in pastoral formation. Even with their brokenness, they, as I, have been called. I have helped to be a healing force and presence in their lives. God has truly been good to me.

Mid-Life

In 1986, I joined the staff at Our Lady of the Lakes Regional Medical Center as a CPE Supervisor, after meeting the various committees in the Southwest Region, a region that had never had an African-American CPE supervisory candidate before. It was through this journey that I came to be certified after a rigorous meeting. I was asked questions that were humiliating, but being able to stand the test, both confronting and being confronted, I was certified in 1985 by the Southwest Region as an acting supervisor. Thanks be to God! While I waited for the committee's decision, I heard the

voice of God. I heard it through Psalm 103, that said again in a loud, clear voice, "No matter what a committee decides, you are My child." I heard it through the psalmist's voice saying, "Bless the Lord oh my soul, and all that is within me, bless His holy name."

After years of further development, in 1988 I successfully directed our center toward full accreditation. And, in 1989 I met the final certification committee and was certified the first African-American woman in the Association for Clinical Pastoral Education. My, my, my, my! Oh, this was affirmation, but it felt as if the journey was not ending, but was moving on. God has offered me many opportunities. I have been able to be a successful pastor. I've also been a pastor under siege and a pastor who was cast out. But, to the glory of God, in 1992, I successfully completed the building of an educational center at Doughty Chapel, African Methodist Episcopal Church, and had seen God bless that congregation throughout a six-year ministry period. As I concluded that work, maybe because I still carried some baggage from the past, I felt that my work there was finished.

I moved on to seeking a new position and was welcomed to the Medical College of Virginia/ Virginia Commonwealth University. Here I am seeing life from many perspectives. I see it as a single grandparent. I see it as a caregiver. I see what is going on in our society as I look upon the faces of young, African-American males who have only one injury, a single gunshot wound. I see it when I see their blood. I see it when I see the tears of their mothers and hear that piercing wail that is like none other—that blood-cringing scream from a mother at the announcement that her child has died. Oh, do I wonder, what is going on in our world? Yet, I see God! I see God, even in this time.

In my own life, I am suffering, because my son is incarcerated. I suffer because I know of the indignities that this system is producing for him and for me and for his children and for his sisters, but I know that as certain as God is alive, that God has been moving even in this event, because Randy has found the God of his mother. God has been dwelling in him and is bringing him through this event. I see it, because God has got His hands on him, and I trust that all will be healed for him—the addiction—and the ministry that he is now called to will be fulfilled.

I don't know where the rest of this journey will take, but as I now come to United Theological Seminary, looking for a Doctorate of Ministry, I come knowing that I am merely a humble servant of God, looking for more skills to meet this present age, to be able to be the intervener between that young man and the last bullet wound, for the one who is hurt, and seeing this experience as a life-changing event. It is my prayer and my hope, as we journey together in this pilgrimage, that God will provide.

My Ministry as Clinical Pastoral Education Supervisor

My role as a CPE supervisor is a fulfillment of my call to ministry. Initially, I understood that my identity as a pastor was primarily in a local church. While I was in CPE training, I acknowledged that I was being called to supervision. During that time, I was privileged to have experienced men as teachers. One of my presenters described this part of my educational journey as "less than holy;" in-fact it was a very difficult time. My struggles focused on some old therapeutic issues that prevented me from fully

utilizing the training process. I was isolated in the training environment; there were no other blacks affiliated with the center that I was training in at the time. All of the faculty, staff, and students were white. I was also a female and no other women had successfully trained in that center as supervisors. At that time, I was unable to give voice to my feelings of isolation, rejection, and abandonment. That pain became the crucible for my learning. Caring pastoral counselors and supervisors helped me claim my authority and clarify my identity.

I realized that the theme of my own story, including pain that I had known in my childhood, was in some way now becoming identified as what I needed to offer to others. My own internal healing was spiritual and emotional preparation to be with students therapeutically. For years I struggled with low self-esteem and wondered if I was accepted. Learning to value and accept myself caused a powerful transformation in my life and I wanted to share this with others. With patients, caring for them came very naturally. I see supervision as the opportunity to care for patients while training ministers. I am good as a compassionate helper to assist students to claim their identity and to risk being vulnerable and intimate enough to allow themselves to be healed as they offer care to others.

I model ministry to others and in turn they are able to reenact the care that they received to utilize it in their ministry. The experiences that I have learned from in pastoral relations with students and patients have provided me with a wide repertoire of information and skills to aid in the healing enterprise and the formation of ministers. I offer these experiences as a guide to students who are learning new and challenging

aspects of themselves and learning new skills. The objectives of CPE provide a very wide stage for ministers to learn about themselves and others. The inclusion of the knowledge of the behavior sciences with theology keeps this model fresh and alive.

The effort of this work, "Pastoral care to victims of violence at the Medical College of Virginia Hospitals," is to explore and learn more in a field that is new to the pastoral care field. Most pastoral care literature addresses an audience that is stable and middle class–not an audience that lives closely with crime and violence. I want to add to this field by recognizing and understanding the needs of marginalized men who are murdered and injured in the streets and their families who cry tears for them. I also want to make the hospital a sensitive and caring place so that those who come here may find healing, as the man did in the parable of "The Good Samaritan." It is my hope that ministers and churches will see the need to reach out to those who have been neglected by society.

CHAPTER SEVEN

RESULTS OF THE MODEL

This model utilized a case study method for the collection and reflection of data. The model was implemented by providing spiritual care to victims of violence at the Medical College of Virginia in Richmond, Virginia. The focus was on African-American males between the ages of eighteen to thirty-five. Over a period of three months, from June 1 to September 1, 1997, the department received 104 calls to respond to trauma cases. These cases all involved intentional injuries. Most were gunshot injuries. The cases that have been reported in this project include interviews with survivors; i.e., people who have had sufficient time to heal and be transformed by the experience of violence and loss of a loved one in their life. The project also includes interviews with a community pastor, a trauma nurse, and a psychologist. These interviews give the individual community leader's perspective on the reason for the increase in violence injury in this city.

Objective 1

To provide direct spiritual care to victims of violence and their families. Chaplains regularly visit patients at MCVH. The uniqueness of this project is that there is a focus on allowing the patient to specifically debrief about the traumatic event. In responding to questions from chaplains patients were willing to explore how the trauma had impacted them, and many reported that through the chaos they had experienced the presence of God. This is the one consistent theme throughout all of the cases that are presented. Individuals also reported their intentions to change their lives. I have observed that pastoral care and evangelism complement each other.

Objective 2

To provide support through the transition. Patients are routinely moved from various places throughout the hospital depending on the care they need. Throughout this study more emphasis was placed on following the patient from one unit to the other and staying in contact with the chaplain on that floor. This is an area that can be improved with better communication among the chaplains and by developing a tracking system.

Objective 3

To utilize the patient's survival skills to cope. This concept was introduced in this study and caused a great deal of learning about post traumatic stress disorder which is a new category in the mental health field. It is appropriate to use this means of exploration with patients because it continues to help them utilize their own story and their own core belief system to make changes in their lives and to find a way of integrating this tragedy.

Objective 4

To conduct awareness seminars in churches. During this project, I have conducted awareness seminars at Morning Star Missionary Baptist Church and at Mt. Olivet Baptist Church. The congregations seemed to be more open to understanding: 1) the severity of the problem, and 2) that it was not as foreign to them as they had initially thought. Although they did not know anyone when they talked about it, they realized that there were neighbors and friends who had been injured; in fact, some were members of their own churches. The results of this awareness seminar is that churches were more willing to be open to welcoming returning victims.

Objective 5

To provide support to victims. Through support groups, care for families was provided. I utilized care teams and existing support groups to support patients. One was the care group at Mt. Olivet that is led by Reverend Rosalind Bradley. This group conducted a memorial service on New Year's Eve. The context associates sponsored a "Healing Through Music" service in October. There is much more that can be done in this area. In following the work with one survivor, B.E., I was invited to go to the juvenile detention center and meet with youth who are awaiting trial for crimes. This was an awareness time for the youth to learn about the impact of violence and to provide them an opportunity to look at hope in their own lives.

Objective 6

To educate clinical pastoral education students who provide ministry to victims of violence. At MCVH, the CPE students provide much of the front line ministry. The results of this project and other activities has caused the pastoral care department to change its method of offering care and to provide routine chaplains who are on duty for four 12-hour shifts in a rotation. Previously, we had beginning CPE students functioning as over-night chaplains. It was finally realized that the intensity and number of injuries that were coming in were overwhelming. At this time, beginning CPE students learn by shadowing the duty chaplain, and later they are observed by the duty

chaplain offering ministry. When it is felt that they are competent, two beginning chaplains provide the coverage of the hospital. The CPE students use the clinical method of learning by accompany a duty chaplain to traumas and continue to use learning from their own autobiographies to strengthen and develop their pastoral identity. They are able to set aside some of their preconceived notions about people and be more open in journeying with them.

Summary

The method has had much impact upon the writer. It has been through being with families and individuals who have experienced a tragedy that I have been able to learn more about my own internal suffering and experience healing. This method has resulted in my desire to learn more about the field of trauma resolution. I believe that this is the way that God is leading me and this has come from being able to identify and learn from individuals who are survivors of tragedy.

The final examining committee consists of the following:

Mentors: Dr. Leah Gaskin Fitchue (not in attendance)

Mentors: Dr. George E. McRae

Dr. Harriet Miller, Faculty Representative

Dr. Glen Routt, Consultant

Dr. Jimmy McCreary, Consultant

Dr. William Augman, Outside Examiner

Reverend Henry Mason, Member of the Peer Seminar

Reverend Rosalind Bradley, Context Associate

APPENDIX

OBJECTIVES FOR CPE

As outlined in the Standards of the Association for Clinical Pastoral Education, the goal of CPE is the development of pastoral reflection, pastoral formation, and pastoral competence, and, where appropriate, pastoral specialization. Specific objectives are:

124.1 --To become aware of oneself as minister and ways one's ministry affects persons and to develop the skills to provide intensive and extensive pastoral care and counseling to persons in their crisis and situation.

124.2 --To understand and utilize the clinical method of learning.

124.3 --To utilize the support, confrontation and clarification of the peer group for the integration of personal attributes and pastoral functioning.

124.4 --To utilize individual and group supervision for personal and professional growth and for developing the capacity to evaluate one's ministry.

124.5 --To develop the ability to make optimum use of one's religious heritage, theological understanding and knowledge of the behavioral sciences in pastoral ministry to persons and groups.

124.6 --To become aware of how one's attitudes, values and assumptions affect one's ministry and to acquire a self knowledge which permits pastoral care to be offered within one's strengths and weaknesses.

124.7 --To become aware of the pastoral role in interdisciplinary relationships and to work effectively as a pastoral member of an interdisciplinary team.

124.8 --To become aware of how social conditions and structures affect the lives of others and oneself and to effectively address these in ministry to others.

124.9 --To develop the capacity to utilize one's pastoral and prophetic perspectives in a variety of functions such as: preaching, teaching, leadership, management, pastoral care and, as appropriate, pastoral counseling.

VIOLENT INJURY REPORTS AT THE MEDICAL COLLEGE OF VIRGINIA HOSPITALS FROM AUGUST 4, THROUGH SEPTEMBER 20, 1997

AUG. 4, 1997, 8:05 p.m. Followed up on referral from Ricky re: TTA . Pt. was N.B. (15 yr. old w/m) who was hit by a car while riding his bicycle. Pt. mother was with him when I entered room. Pt. went to M7CW. C.A.

AUG. 5, 1997, 5:03 p.m. TTA for N. W. 82 yr. old w/w who sustained self-inflicted GSW to abdomen. Pt taken to OR immediately - Niece contacted and en route. To be notified when family arrives. A.L.

AUG. 7, 1997, 4:01 a.m. TTA to TER hit and run , pt. K. T. 34 yr. old b/m pedestrian vs auto- contacted pts. father and supported him upon his arrival. Yellow area as of 8:15 this morning.

11:38 p.m. TTA for pt. S. H., 32 yr. old w/m who was assaulted and shot. Provided pastoral support to family upon their arrival. Pt. transferred to NSICU after surgery. Contacted FFC. C.A., R.H.

AUG. 8, 1997, 5:30 p.m. T.P from Chaplin M. H., Williamsburg Community Hospital regarding C. R. 21 yr. old who O.D. on tylenol. Pt is being transferred to MCV. Chaplain requested follow up call (757) 259-6683. A.L.

7:05 p.m. TTA for T. B. 31 yr. old w/f with GSW to lower abdomen. Pt taken to OR within 15 minutes. Family contacted. A.L.

11:20 p.m. TTA for J. C., 89yr.old w/m victim of an assault by man who broke into his home. Multiple stab wounds to head, arm, chest, stomach. Taken to OR at 11:55. No family contacted. W.D.

AUG. 9, 1997, 4:38 a.m. TTA for pt. W., Friday, 38 yr. old b/m, stab wound victim. Pt. stable, no family present. Support staff. W.D.

10:48 p.m. TTA for 3 young men injured while attending an activity at the Arthur Ashe Center. 1) S. W. 15 yr. old b/m received a single gunshot wound to the lower abdomen. Went to surgery for removal of bullet. 2) R. G. 17 yr. old b/m received a single gunshot wound to the right hip. Bullet was removed in the TER and pt released. 3) C. C. a 16 yr. old b/m was said to have been beaten. Patient was drowsy but able to respond. Assisted in contacting and meeting families. Offered presence and contact/information flow with medical staff during very hectic times. Will continue to follow up throughout the night. K.M.

10:25 p.m. TTA to TER for pt. W. W. 32yr.old b/m who had been hit in the head with a beer bottle. Pt's sister had come with him. Provided support and assistance to her and another sister who arrived later. C.A.

AUG. 11, 1997, 6:26a.m. TTA to TER for pt. W. B. 40yr.old b/m who sustained stab wound to left abdomen with 4-6 inch buck knife. Pt. stated his wife stabbed him. Police officer stated that family knew, but no one has come to hospital yet. Pt. went to OR. C.A.

3:45 a.m. TER pt. R. S., GSW to the stomach referral to B. W. for follow up. Offered support. R. went to OR and will go to STICU. Refer to C. J.H.

AUG. 12, 1997, 2:12 p.m. FFA for pt. T. C., 25 yr. old w/m involved in an industrial accident. Provided support to family throughout the evening as they arrived. R.H.

4:45 p.m. TP to M-ER for family of V. S. who had OD'd on drugs. Family had been waiting for while with pt. for word on her condition. Made arrangements for daughter to see her and talked with husband about family dynamics. R.H.

10:45 p.m. TP to TTA G. L. (HX) 34 yr. old b/m stabbing victim. Patient was taken to the OR 2:15. Patient's mother and other family members arrived. I was called to ER to assist. Offered support and took them to surgery waiting room on M1. Called OR for information. J.H.

AUG. 14, 1997, 9:35p.m. TTA for man XI, a 30yr.old man admitted with GSW to the chest and abdomen. I offered presence and listening support to MVA pt . in bed #3 while the GSW pt was sent to OR. M.D.

10:30 p.m. TTA for 42 yr. old man admitted with a knife wound. Offered support to staff and Henrico Rescue Squad as they told their story. M.D.

AUG.16, 1997, 12:15 a.m. TTA C. R., 28 yr old b/m, shot 3 times to chest, 2 times to arms. Pt. pronounced at 12:26 a.m. Fiancee and friend present. Provided support. They left to go tell his mother. Plan to return to MCV for viewing. Supported staff and Richmond Police. W.D.

3:26 a.m. TTA pt. R. M., 48 yr.old b/m victim of stab wound by girlfriend. Pt treated and released. Supported pt and staff. W.D.

11:40 p.m. TTA to 2 pt- M. R. and O. R. two inmates from Greenville Correctional Facility involved in a small riot when 8 or more inmates were fighting. Mr. R. 23yr.old male with multiple stab wounds was in bed and never became conscience. Mr.R. was wake and talking (colorfully) to nurse and 6 guards in trauma room. W.M

AUG. 18, 1997, 1:00 a.m. TTA to TER for pt. S. D. 24 yr. old w/m who was assaulted. Pt. received laceration to head. Provided support to pt's girlfriend who was attempting to contact brother. Escorted her back to see patient. C.A.

5:54 a.m. G. G., 25 yr. old b/m GSW to leg. Patient didn't want anyone called. Patient went to O.R J.H.

9:15 p.m. TTA to TER for D. W., 43 yr. old b/f with GSW to neck and arm. Another shooting victim was D. L. J., 22 yr. old b/m. Offered emotional and spiritual support to family and friends of both patients, coordinated and exchanged information between the victims and families, helped with crowd control and security. 1:45 a.m. J. went to M9C at 1:45 a.m. and W. was in Angio until 4:30 a.m. with the possibility of going to surgery. Coordinated passing information to her family as they waited in surgery area. Security called about them and relatives of George Green, who were now present and requesting updates on where he was located. J.H.

12:45 a.m. TTA for XM b/m GSW to multiple places sent to OR. TP at 3:46 a.m. by nurse requested more info. because XM had died in surgery. J.H.

7:55a.m. Present with the brother and sister of Mr. XM (R. L. L.) a 33 yr. old b/m who had been shot during the night and died in the OR. Supported family as they were told of patient's death and assisted them in making phone calls. Provided them a bereavement packet and remained with them until they left the hospital to go tell their parents. D.F.

AUG. 20, 1997, 6:58 p.m. TTA for M. D., GSW to the leg, sustained broken femur. Provided support to family upon their arrival. Kept them updated about the status of his surgery. Had prayer. R.H.

AUG. 21, 1997, 3:22 p.m. TTA for pt. M. P. 17 yr. old b/m who had been shot in the buttock. Offered presence and emotional support to pt who was scared and tearful. Contacted pts. grandmother. Remained with pt til he was transferred to CT. Referred to Duty Chaplain for follow up when family arrived. D.F.

11:40 p.m. TTA to TER, K. N., 39 yr. old c/m GSW to neck. Taken to OR. Supported staff. B.D.

AUG. 23, 1997, 6:38 p.m. TTA for Mr.XQ (G. J.) 22 yr. old b/m who was admitted with GSW to the abdomen and finger. I offered support as Mr. J. was taken to the OR, and pt rep. as she called his girlfriend. M.D.

AUG. 24, 1997, 11:08 p.m. TTA to TER for pt. A. L. 10 yr. old b/m, who was hit by a car while riding his bicycle. Pt. Sustained a large bleed on his brain and went quickly to CT and then straight to OR. Provided support to pt's mother and other family members. Escorted to SWR, offered prayer. Pt. went to PICU after surgery. C.A.

AUG. 25, 1997, 8:00 p.m. TP to PER for pt J. P. 4 yr. old b/m who sustained GSW to chest (Begun.) Provided support to pt's mother and father as they awaited information on tx plan from physicians. X-rays eventually revealed that the BB had missed all vital organs. Pt. went to PICU for observation. C.A.

11:22 p.m. TTA to TER for pt. M. T. 18yr.old b/m who sustained GSW to the back. Pt's lung and liver were affected. Pt. went to CSICU. Provided support to pt and family. C.A.

11:39 p.m. TTA to TER for pt. P. C. 18 yr. old b/m who sustained GSW to abdomen. Pt. went to OR. Provided support to pt's family in SWR. Pt. remains in PACU. C.A.

AUG. 28, 1997, 6:40 p.m. TTA for F. D., a 53 yr.old b/m who had been assaulted.. B. C. asked to handle this if I would go upstairs for. D.D.

AUG. 29, 1997, 10:51 p.m. TTA for D. C. a 33 yr. old b/m with a GSW. I offered support to him and his family until he was taken to surgery to remove bullet that was possibly near his lower spine. He was also told he may wake up with a temporary colostomy. (Final room assignment?) W.M.

AUG. 31, 1997, 4:35 a.m. TTA for L. W. young b/m with GSW to left leg. Police officer informed parent. Offered support to patient and staff patient received a cast in TER and will be admitted. K.R.

SEPT. 2, 1997, 12:55 a.m. TTA to TER pt S. B. (H.) 37 yr. old b/f who was stabbed in the back, provided support and contacted police to locate family to insure safety of her 14 yr. old daughter. Provided emotional and spiritual support until pt was discharged. B.W.

3:00 a.m. TTA to TER pt .M.S. 18 yr. old b/m with GSW to the shoulder and hand. Provided support to pt and family upon arrival. Unidentified b/m taken to OR as of 7:20 a.m. OR patient is still recovering. Pt. admitted as Mr.X U. B.W.

SEPT.5, 1997, 9:45 p.m. TTA to TER for pt. G. A. 31yr.old Arab/m who received GSW to chest. Pt. was pronounced dead shortly after arrival. Pt's brothers and cousin arrived about 10:30. Escorted physician to speak with family. Provided bereavement packet and arranged for some family members to view body. Escorted them out. C.A.

SEPT. 6, 1997, 4:45 a.m. TTA to TER for pt. Mr.XX(C. S.)est. 20yr.old w/m, who had been assaulted to the face and head. Pt. Was unable to speak clearly and no ID was found on him. Could not give next of kin information. Police later ID'd him. C.A.

11:34 p.m. TTA to TER for pt. D. D. 25 yr. old b/m who sustained GSW to arm and leg. Upon evaluation it was found that bullet in arm went into mid-torso as well. Pt went to OR quickly. Pt's family had just begun to arrive as decision was made to take patient to OR. Escorted surgeon to get consent from family and then arranged for one of the ER attendants to give family more detailed information. Escorted family to SWR. Pt eventually went to NSICU, but family had left. C.A.

SEPT. 7, 1997, 4:47 p.m. TER - pt. M. P. 25 yr .old./o w/m GSW self inflicted accidentally to throat. Patient was alert and responding. Large family arrived (including parents.) Provided emotional support to family who were very distraught. Served as liaison between staff and family. Escorted family to surgical waiting rm. Pt went to CSICU. R.B.I.

6:42 p.m. TER- while in TER pt XY approx. 40yr.old w/m with 3 GSW to the chest was brought in after a car accident where it was discovered he had been shot. No ID was found so next of kin could not be notified. Patient's chest was open, given sedative and quietly transferred to OR. R.B.I.

8:25 p.m. Back-to-back TTA's (approx. 1min. apart) to TER . Upon arrival, found in TBI pt K. H. 40 yr. old w/m who had sustained multiple GSW's to arms and legs. Pt. asked me to call his ex-wife and later asked detective to call a sister. Family arrived some time later. Arranged for them to see him just before he went to Angio and facilitated communication with Medical staff. Pt. Went to M10C. C.A.

SEPT. 8, 1997, 9:51 p.m. TTA to TER for pt. J. D. 36yr.old b/m who sustained 2 GSW to his back. Pt's family arrived shortly after pt did. Arranged for them to see pt briefly them escorted them to SWR when pt went to OR for lap. Offered prayer. Pt. went to M9C. C.A.

SEPT. 10, 1997, 11:20 a.m. TP TTA to TER for J. H. 20 yr.old b/m GSW to head. Offered emotional and spiritual support to large group of family and friends. Escorted parents to see their son after they were notified that there was nothing that could be done for him due to the extent of his injury to the brain. The FCC protocol was not followed correctly. Dan and Pam will follow patient. J.H.

SEPT. 12, 1997, 2:06 a.m. TTA-TER GSW to neck, A. S., 23yr.old b/m expired. TOD 2:14 a.m.- provided support to family, escorted to view the body. B.W.

3:10 a.m. TTA -TER Assault , pt. C. Y. 24 yr. old b/m hit on head trauma. Provided support to mother and father. B.W.

4:13 a.m. TTA-TER, GSW pt. D. M. 33 yr. old w/m . Provided support to pt's mother on her arrival. B.W.

SEPT. 14, 1997, 9:14 p.m. TTA to TER for pt. Mr.XC (approx. 25 yr. old b/m) who sustained GSW to chest. Pt was being coded when I arrived and had been down a substantial amount of time. Spoke with K. M. (weekend SW for ER) and asked her to call me if we received any ID, family ,etc. She contacted me later to let me know he died and we still had no ID. Patient rep. later gave me a tentative police ID. Pt had already gone to morgue. As of 12:10a.m., still no family. C.A.

SEPT. 15, 1997, 5:05 a.m. TTA to TER for pt Mr. XD around 34yr.old b/m , who sustained GSW to R-clavicle. Pt's ID was not found and he was unable to speak clearly enough to recognize his name. Pt was sent to angio. C.A.

SEPT. 16, 1997, 10:46 p.m. TTA to TER for pt A. M.,51yr.old b/f who fell and hit her head while trying to break up a fight between her sons. Originally lost consciousness and seemed to have altered mental status. No head injury was found and pt will be discharged. Provided support to pt's family as they awaited info. and opportunity to see her. C.A.

11:00 p.m.TTA to TER for pt. Ms. XE(real name B. P., ---yr.old b/f) who sustained GSW to neck. Pt. was hysterical upon arrival and could not give name, etc. Eventually she was able to give us her name and phone number of husband, whom I could contact. He arrived and I facilitated conversation with physician and visit with patient . Pt. went to Angio and has a bed ready on M9C. C.A.

SEPT. 18, 1997, 10:4 6p.m. TTA to TER - GSW to shoulder (liver contusion) 17 yr. old b/m T. B.. Provided support to mother and grandmother upon arrival. Pt. admitted to M10C rm.224-A. B.W.

11:47 p.m. TTA to TER to support C. H. 29 yr. old b/m, GSW to buttocks and groin. Provided supportive presence. Pt. admitted to M9C rm. 226. B.W.

SEPT. 19, 1997, 7:04 a.m. TTA to TER to support pt. E. S. 33 yr. old b/m who had been stabbed in abdomen. Notified friend 233-8076. Who will come to support pt. B.W.

11:37 p.m. TTA to TER Assault and battery with a bat pt. E. F., 35 yr. old b/m. Pt. admitted to N9 33A. Provided support and spiritual presence. B.W.

SEPT. 20, 1997, 12:35 p.m. TTA for 27yr.old w/m K. H. who received 2 GSW . Patient was almost immediately taken to OR. TER attempted to stabilize him first. No family info to use for contacting a relative. K.R.

'No fear, no life expectancy' on city streets

Media use violence to lure numb communities, researcher says

BY GORDON HICKEY
TIMES-DISPATCH STAFF WRITER

Colleen McLaughlin remembers the night she was in the emergency room at the Medical College of Virginia Hospitals while doctors attended to a black teen who had been shot several times.

The hospital had called the boy's mother and told her that her son was wounded and could die.

When the mother arrived at the emergency room, she asked whether there was a place she could store the groceries she had stopped to buy on her way to the hospital.

McLaughlin was appalled. She felt, she said, like the only person there who cared about the child. But she also said that the woman and her son probably were so inured to violence, so reconciled to the inevitable, that the boy's shooting came as no surprise.

And that, McLaughlin said, is a huge problem Richmond will have to deal with if it ever is going to remove the stigma of being one of the country's murder capitals.

McLaughlin is an assistant professor of surgery at MCV. She also works for the state Department of Criminal Justice Services' Criminal Research Center, where

PLEASE SEE **VIOLENCE** *PAGE* **A6** ▶

THE SOUR

SCARS IN QUESTION. An assistant medical r and a magazine executive disagree about the this advertisement imparts.

SECTIONS VIRGINIA / METRO B SPORTS

Researcher: 'No fear, no life expectancy' on streets

▼ VIOLENCE *FROM PAGE A1*

she does research on violent crime.

She made a presentation recently to Richmond City Council's Public Safety Committee that was based on two years of study of gunshot victims admitted to MCV. She said what she found makes it clear to her that violence has become such an accepted part of the African-American experience that it is being used as a marketing tool by the national media.

She showed a slide of a magazine advertisement for clothing in which the models were attending a young man's funeral. Another magazine ad shows an attractive black woman, dressed in a red bustier, cradling the head of what looks to be her dead son in her lap.

Then there are the bulletproof stadium jackets. They can be bought for $1,700 each.

"Protect your life in style," the ad reads. The company "makes a line of bulletproof jackets that can stop a 44 Magnum at close range. ... Their cost may seem steep but it's a smart, safe and *legal* way to fight violence."

In the undated premier issue of a hip-hop magazine XXL, there is an article about Khallid Muhammad, former aide to Nation of Islam leader Louis Farrakhan. A picture accompanying the article shows Muhammad holding an assault rifle. He is surrounded by small children, several clearly younger than 10, holding up clenched fists.

Another popular hip-hop magazine, The Source, includes a jeans advertisement featuring a black male, naked from the waist up, who has what looks like a scar from a knife wound across his upper abdomen and a bullet wound in his lower left side, McLaughlin said.

The scars, McLaughlin pointed out, are called tattoos in popular urban culture. They are displayed proudly as bragging points, rites of passage, she said.

And, according to McLaughlin, they define what she and her emergency-room acquaintances call the box model: "Once they enter the cycle of violence, they leave in a box — either a pine box or a box with bars."

Peter J. Ferraro, associate publisher for advertising at The Source, said his magazine is careful about the ads it accepts. No guns are allowed, no liquor or tobacco, he said.

"We take the reader very, very seriously," he said.

Besides, he said, it is impossible to say that the scars on the model in the jeans ad weren't surgical. And he disagreed with McLaughlin's notion that teens admire scars.

"It's tough on the streets, but kids don't want to have scars," Ferraro said. "It's almost an insult to our readers and teen-agers across America to suggest that they are so mindlessly impressionable."

Ferraro said the complaints seem to mirror what has been said, particularly in the white press, about hip-hop and rap music.

"The media never talks about the positive aspects of it," he said. "Hip-hop is really the rock 'n' roll of this generation of kids," he said. He added that there is "a lot of racism mixed in" in the criticism of it.

McLaughlin pointed to an ad in another magazine featuring a cigarette and an article that discusses being a pimp as a career choice. The message is so pervasive "that even kids who aren't involved in drugs are emulating the lifestyle," McLaughlin told the City Council committee.

> *"If a kid thinks he's going to die by 21, there's no incentive to education."*
>
> COLLEEN MCLAUGHLIN
> SURGERY PROFESSOR AT MCV

McLaughlin has numbers to back up her fears. She studied 65 teenage male shooting victims who were admitted to MCV during the past two years. She said 82 percent of them had "identifiable risk factors," such as drug use, in their backgrounds. Sixty-six percent were involved in the juvenile court system before they were shot, she said.

What McLaughlin also found is that a male teen who has been involved in the court system is 22 times more likely to get shot than one who hasn't been in the court system. The young shooting victims were invariably "in the wrong place, at the wrong time, doing the wrong things with the wrong people," she said.

Her study found that one in five of the men incarcerated in Richmond for selling drugs also has been shot.

If a person sells drugs, she said, "you're more likely to get shot than to win a free ticket in the lottery.... Richmond is an extraordinarily unsafe community to sell drugs."

When McLaughlin began to compile what she thought were some startling statistics about the likelihood that young black males will be shot, she looked for something to compare them with. She found the Civil War.

In that bloodiest of all American wars, the injury rate from firearms was about 13 percent. "That's about what we have here," she said.

By comparison, 2.3 percent of the men serving in the Vietnam War were killed or injured, she said.

While black males are the immediate victims of the violence, the entire society suffers, she said.

McLaughlin found that four out of 10 people who are victims of violent crime will be injured at least one more time. Because hospitals such as MCV pass on the cost of treating those victims to other patients, everybody pays, she said.

The national cost of violence has been put at $4 billion a year, McLaughlin said. To put that in perspective, the Federal Emergency Management Agency, which doles out disaster relief after hurricanes and floods, spends an average of $2.7 billion a year.

Also, she said, "victims are twice as likely to father children in the community." Since those victims are teen-agers, so are the children's mothers.

She said that people who think the violence doesn't affect them are wrong. "It's socially irresponsible and economically dumb to say 'that's not my problem,'" she said.

[illegible] pointed out, aren't easy. She echoed Police Chief Jerry Oliver's observation that "we need to look at the other side of the crime tape. ... Someone has lost their life and people are standing there eating snack food."

She was talking about the familiar yellow plastic tape police use to cordon off crime scenes. Often, people gather at the tape to watch what the police are doing.

Oliver listened to McLaughlin's presentation to the City Council members and criticized rapper and television actor Ice-T. He called for a boycott of the television show "Players," starring Ice-T.

Deputy Chief Fred Russell said that crime prevention must start as early as possible. "Good crime prevention starts with good prenatal care," he said.

Others, such as Sandy Stovall, executive director of Historic Jackson Ward, said youngsters need something to do with their free time. She also called for an end to violence on television and in the movies.

Stovall added that she didn't see any future in more prison sentences. "I don't want to participate in another activity that locks up young people," she said.

Dr. Charles Price, chairman of a local civic group, called for nothing short of a full-blown attack on the kind of media representations of violence that McLaughlin described to the committee. He called for "a major war against the media."

Richmond, which has received national attention because of its high murder rate, could lead that charge, he said.

"Richmond could take a leadership role in its own behalf to speak out against this."

Price is chairman of the Far West Neighborhood Teams and is involved in two anti-crime groups, Citizens for Safe Streets and the Coalition for a Safer Richmond.

What McLaughlin sees too often is a kind of condom approach to crime that is similar to what's being done to combat AIDS — the disease is still there, but people are looking for ways to block it from affecting them. The bulletproof stadium jackets are a prime example, she said.

She also said she sees no future in locking up more kids. "Building more jails to fight crime is like building more graveyards to fight disease."

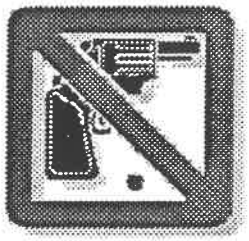
McLaughlin favors "an attempt to be more global." She admires Richmond's Team Zero Tolerance, a city program developed under former City Manager Robert C. Bobb that tries to channel all city services, including such things as the parks department and the Office of Economic Development, toward crime prevention.

"That's were we're going," she said.

She said that whatever is done, juveniles must be convinced that violence isn't glamorous, and that they have something to live for.

"If a kid thinks he's going to die by 21, there's no incentive to education," she said. "I see kids with no hope, no fear, no rules and no life expectancy."

Economic Costs of Gun Violence



The cost to treat victims of firearm violence is overwhelming. Firearm-related injuries make up 0.5% of all injuries, yet they represent 9% of total cost of injury over a lifetime. Almost 85% of all health-care expenses due to gunshot injuries and fatalities is charged to taxpayers.{79}

Estimates of the total cost of gun violence vary. Researchers Wendy Max and Dorothy P. Rice of the University of California School of Nursing estimate that the 1990 costs of direct medical spending and lost productivity in the United States totaled $20.4 billion.{80} In a study appearing in the Textbook of Penetrating Trauma, researchers concluded that the total 1992 cost of firearm violence was $112 billion when taking into consideration direct medical costs, lost productivity, and lost quality of life. This study also reported that each of the estimated 4.91 billion bullets sold in 1992 represented $23 in costs due to firearm violence, including $0.60 in medical and emergency services, $7.20 in lost productivity, and $15.10 in pain, suffering, and lost quality of life.{81} One news article reported that the average expense of each incidence of gun violence totals well over $300,000.{82}

The financial costs of gun violence place a heavy burden on trauma care centers. Between 1986 and 1991, 92 of the 549 trauma care centers in the United States closed.{83} Because many gunshot victims are uninsured, almost 85% of medical charges due to gunshots are paid by taxpayers through public health care and public debt.{84}

Hospital fees are structured so that insured patients cover the losses due to uninsured patients. This means that private health insurance plans compensate most of the medical costs caused by guns, even though they pay for only one-fourth of the actual injuries. The costs of treating uninsured gunshot victims that aren t picked up through public health care are passed on to those privately insured through both higher premiums. Moreover, hospitals must charge more for particular procedures in order to compensate for the uninsured. Therefore non-gun owners who are taxpayers and privately insured are paying for the problems created by widespread gun ownership and availability.

Black Child Gun Deaths Up 270%

Nearly four times as many Black children died from gunfire in 1993 as in 1984--a 270 percent increase, according to a BCCC-CDF analysis of unpublished National Center for Health Statistics data. A Black child in America dies from gunfire every 3 hours and 19 minutes.

"The morally unthinkable killing of children has not only become routine but is increasing in the world's leading democracy," said Marian Wright Edelman, Children's Defense Fund president and BCCC Working Committee member.

Black 15- to 19-year-old males suffered the greatest gun toll among U.S. children and teens. They were five times as likely as their White peers to be gun victims. Gun violence is now the leading cause of death among all Black 15- to 19-year-olds, and the third leading cause of death of Black 5- to 9-year-olds.

The 2,618 Black child and youth gun deaths in 1993 included 2,221 homicides, 187 suicides, and 174 accidents.

The growth in the number of children killed by gunfire has prompted Edelman to call for immediate preventive action by parents, communities, policymakers, and all others who influence the lives of children:

- The President, Congress, and state and local officials must commit to ending the senseless gun deaths of children.
- Every level of government must take stronger action to regulate guns as the dangerous products they are, and efforts to repeal or weaken the assault weapons ban, the Brady law, and other measures designed to protect children and the public must be rejected.
- Communities of faith, joined by parents and other citizens, must speak out and rise up to meet the moral challenge of gun violence.
- Parents and other adults must understand the danger of keeping guns in the home. A gun in the home is far more likely to be used to kill a family member or friend than an intruder. Those who choose to own guns must keep them securely locked away, separate from ammunition, to keep them out of the reach of children and those who harm children.
- We must create safe places and positive alternatives to the streets for children and youths after school, on weekends, and during the summer. Edelman called for increasing the number of summer jobs for teens and strengthening crime prevention measures.
- Communities should conduct "neighborhood audits" of assets and liabilities to children's safety, and work together to build on assets and reduce liabilities.
- Every sector of society should work to reduce the glorification of guns and violence in our culture and media, and end the marketing of guns to children.

The BCCC-CDF analysis also found that:

- The number of Black children and teens killed by gunfire in 1992 and 1993

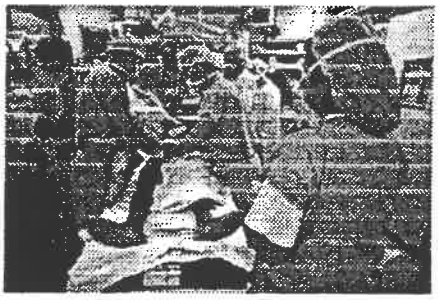
U.S.News

Cover Story

Read about gun-critics' recent gains in court, a *U.S.News Online* special

GUNS, MONEY & MEDICINE

The proliferation of powerful new weapons has sent the cost of crime spiraling. Here's why you pay



One glance in the rearview mirror of his 1978 Cadillac Eldorado and 21-year-old Dewayne Bellamy knew that his evening was over. Approaching the car near a decaying corner of the nation's capital was the teenage son of a woman with whom Bellamy was having an affair. The boy had a gun. Before Bellamy could draw from his own arsenal of semiautomatic weapons, he heard the familiar pop of a 9-millimeter pistol. There was no pain, no blood. Only after he awoke from a coma three days later did Bellamy receive two pieces of news. The first was that he had been shot 13 times. The second was that he would never walk again.

From the moment paramedics lifted him into the ambulance, Bellamy became the charge of the nation's taxpayers. And for the next eight months, the meter would never stop ticking. Covering everything from $3 scalpels to $2,283 CT scans, Bellamy's hospital bills would ultimately total $562,561. Doctors' fees would add tens of thousands more to the tab. For Bellamy, a onetime car thief who used to earn $5,000 a day selling crack cocaine, that's big money. But he doesn't worry about it. After all, he's not paying the bills.

In emergency rooms and rehabilitation centers across the country, Bellamy's is a depressingly familiar tale. By the year 2003, according to the federal Centers for Disease Control and Prevention, gunfire will have surpassed auto accidents as the leading cause of injury death in the United States. In seven states, it already has. But unlike victims of car crashes, who are

almost always privately insured, 4 out of 5 gunshot victims are on public assistance or uninsured. That means taxpayers bear the brunt of medical costs that have spiked nearly ninefold in the past decade, to a stunning $4.5 billion a year.

Nationwide, the number of violent crimes has held steady for the past four years, yet gun sales continue to soar. While most gun owners buy their weapons legally, keeping them for self-protection and recreation, a flourishing illegal-drug trade has caused a dramatic rise in the number of powerful semiautomatic weapons used to commit crimes. The result is a flood of new gunshot victims to the nation's emergency rooms.

Multiple wounds. Although injuries from military-style assault weapons are rare, multiple wounds inflicted by semiautomatics such as 9-millimeter pistols are becoming so common as to make some trauma specialists practically nostalgic for the days of the cheap Saturday night special. "It seems like we never see just one shot anymore," says orthopedic surgeon Andrew Burgess of the University of Maryland's shock-trauma center in Baltimore. The increased firepower means doctors are saving fewer patients--and seeing greater damage to those who do survive.

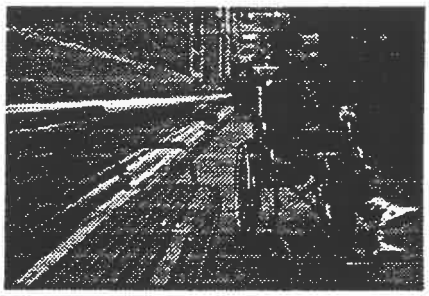
Today's gunshot victims are a distinctive breed. Headlines highlight shootings of innocent bystanders, but the fact is that probably half of gun homicide victims--in some cities as many as 70 percent--are offenders themselves. They are due no less care, doctors say, but they confront modern medicine with an unsettling paradox: Physicians invest countless hours at huge expense to bind wounds and even heal their gunshot patients, only to return them to the streets, where many promptly resume a life of crime. "About 20 percent of our gunshot victims are what we call our `frequent fliers,' " says Burgess. "It's not as if they leave here and find Jesus."

Criminals or bystanders, those shot by semiautomatic weapons can test the limits of even the best emergency care. Lamarr Wilson of Newark, N.J., was one such victim. Shot seven times with a semiautomatic, the 23-year-old was riddled with so many holes that doctors in the trauma unit of the University of Medicine and Dentistry of New Jersey couldn't treat them fast enough. "We'd plug up one hole, only to find two more," says Tonni Glick, an emergency room nurse. The perforations caused the contents of Wilson's bowels to spill into his lacerated vital organs. Wilson's abdominal skin eroded so badly it had to be replaced with a sheet of plastic wrap. Altogether, he endured 14 different surgical procedures. "This one, we never thought he'd make it," says Glick. "But these young guys are tough.

We saved his life." A Medicaid patient, Wilson spent 61 days in the hospital. The bottom line: $268,181.

In the seemingly endless debate over gun control, one fact is unassailable: Gunshot patients are far more expensive to take care of than are victims of other kinds of crime. A typical stab wound, for example, cost $6,446 to treat in 1992; the average gunshot case cost $14,541. Although gunshot wounds account for fewer than 1 percent of injuries in hospitals nationwide, they generate 9 percent of injury treatment costs. That's because more than half of all gunshot victims require expensive emergency surgery. Typical are laparotomies (average cost at one urban hospital: $41,000), thoracotomies (average cost: $26,000) and procedures on the neck and extremities. And that's often just the beginning: About a fifth of all gunshot victims require additional surgery later on.

"Disruption." One reason for the higher treatment costs is physics. A bullet causes trauma to human tissue by transmitting energy beyond the capacity of the tissue to absorb and dissipate it. That causes what doctors call "disruption." The extent of the damage depends on the size and speed of the bullet and the type of tissue affected. A bullet can stretch human tissue, creating an opening that in the most severe cases may expand to many times the size of the bullet. Whether the cavity is temporarily or permanently damaged depends on the body area affected. Elastic tissue like that of a bowel wall is more resistant to permanent damage; inelastic tissue like that of the liver and brain is less so. "If a rubber ball and a raw egg of equal weight are dropped on a cement floor from the same height, these two missiles of equal kinetic energy will sustain different degrees of damage," explains Dr. Jeremy Hollerman of the Hennepin County Medical Center in Minneapolis. "The rubber ball behaves like skeletal muscle or lung, the raw egg like the brain or liver."



At higher velocities, bullets pack more destructive force, causing more extensive damage to soft tissue. Bullets fired at high velocity also tend to create a kind of suctioning action when they strike human tissue, carrying external bacteria deep into internal wounds. (Contrary to popular belief, bullets are not sterilized in the heat of firing.) Slugs are often left in the body when their removal poses a greater danger to a victim, but they can cause lead poisoning and degenerative arthritis if lodged in a joint. Bullets fired at high velocity are also more likely to shatter when they strike bone or metal, producing multiple and even more destructive projectiles. Says Dr. Kenneth Swan of the University of Medicine and Dentistry of New Jersey: "In the face, these secondary (bullets) often cause more damage to the brain and

eyes than the primary bullet."

"T10 complete." When they survive, victims of multiple gunshots almost always go on to live more complicated--and more expensive--lives. Nestor Cantor, 22, of Brooklyn, N.Y., took seven shots in the small of his back from a 9-millimeter semiautomatic fired by a hit man in Richmond Hill, Queens. The bullets exploded, driving lead fragments deep into his spinal cord. Extensive operations repaired lacerations to his bladder and liver and drained fluid from his lungs. The doctors call Cantor a "T10 complete"--paralyzed from the waist down. Two weeks in the intensive care unit, 3½ months at Bellevue Hospital and 1½ years in a public rehabilitation facility have generated a Medicaid bill in excess of $300,000. "I never see what it costs," says Cantor. "I haven't paid anything out of my pocket."

At George Washington University Medical Center in Washington, D.C., former Medical Director Keith Ghezzi, an emergency room physician, totes up the financial toll of a weekend of violence in the nation's capital. A typical gunshot patient spent 16 days in the intensive care unit at $1,487 per day. The patient required drugs costing $13,580, X-rays at $2,738, and bandages, tubes and miscellaneous supplies totaling $16,280. Nursing care, physical therapy and other services added thousands more to the bill. By the time the man was discharged from the hospital, he had racked up a bill of $100,838, not including doctor's fees. Medicaid will pay about 70 percent of the bill; the patient will pay nothing.

The story is repeated every few days. Last year, a homeless man who had served time for armed robbery and assault was taken to George Washington after he was shot while wielding a knife outside the White House. In just two days, the man received more than $70,000 in medical care. He died. The hospital ate the cost of his treatment.

Cost shifting. Such cases show how handgun violence affects Americans who have never even seen a gun or heard one fired in anger. Like most institutions, George Washington covers the costs of treating uninsured and underinsured patients by increasing the bills of those who do pay. Such cost shifting, a recent report to Congress estimated, forced private patients to pay an average of 29 percent above the actual costs of their care in 1993. According to one study, the University of California-Davis Medical Center, despite incurring three-year losses of nearly $2.2 million on gunshot victims, actually made a profit on its trauma center, so heavily did it shift the burden to patients who could pay.

As health maintenance organizations demand more and more savings, however, hospitals are finding it more difficult to pawn off on anyone the costs of the uninsured. The consequences for trauma units are dire. Once sure-fire moneymakers, more than 60 urban trauma centers have closed in the past 10 years, leaving less than one quarter of the nation's population residing anywhere near top-flight trauma care. In a study by the General

Accounting Office for members of Congress, all the shuttered trauma centers blamed their troubles on the growing burden of uncompensated services--millions of dollars of which resulted from treating indigent victims of handgun violence.

For every patient who dies from a gunshot wound--and there were 39,720 in 1994--three others are injured seriously enough to be hospitalized. Of those, one on average suffers from a disabling, lifelong injury. The worst injuries are to the spinal cord, and the higher on the cord the blow, the greater the area paralyzed. If a patient is injured anywhere between the first and third cervical vertebrae, for instance, he may lose all feeling from the neck down. Most spinal-cord-injured gunshot victims are paraplegics, paralyzed only from the waist-down.

Eddie Matos was unluckier than most. In the past six months, the 21-year-old former drug dealer has not moved from his room at New York's Goldwater Memorial Hospital, where he keeps the shades pulled tight and watches soap operas and videos all day. He could motor around the grounds in the $5,000 electric wheelchair he operates by puffing on a straw. But why bother? he says. He sees the same old patients, and they all look like him. Before his accident, Matos was a prospering businessman. He had four "spots": three for crack, one for cocaine. One spot could make $11,000 on a weekend; Matos kept $2,000. The money bought cars--a Cadillac, a Pathfinder, a Mustang and a Volvo. It bought jewelry and his own apartment. It also paid for a 9-millimeter semiautomatic pistol. "My favorite," Matos says. "It does damage."

He should know. One night in September 1990, another man with a 9 millimeter jumped Matos outside a grocery store and shot him once in the neck. The gunman has since "gotten his," Matos says. But his own life is shattered. Lying in the quadraplegic ward of the aging city-run hospital, his only movements are the painful spasms that convulse his muscles every so often. He cannot feed himself or breathe without a ventilator. He must clench a wand in his teeth to turn the pages of a book. Matos has stayed at Goldwater longer than any other gunshot victim. His treatment has cost the public well over $1 million.

Aiming to maim? For patients paralyzed by gunfire, bills like Matos's are not uncommon. Quadraplegics, paralyzed from the neck down, require round-the-clock care. They need aides to change catheters, tracheotomy tubes and bladder bags; to feed, bathe and clothe them; to help wean them, if possible, from their ventilators. Unable to cough, their lungs must be suctioned several times a day to prevent pneumonia, which threatens lives already shortened by ventilator dependency. Bladder infections, which strike with troubling frequency, must be attacked aggressively or they will spread. Beyond medical care, there is arduous physical therapy to prevent muscle atrophy and occupational therapy to help patients function in a nonhandicapped world.

All in all, a bullet in the spinal cord is an expensive proposition. In 1992 dollars (the most recent figures available), the National Spinal Cord Injury Statistical Center estimated first-year medical costs for a high quadraplegic (injured in the uppermost cervical vertebra) at $417,067, plus $74,707 for each year thereafter. The first-year costs for a paraplegic were $152,396, plus $15,507 for each year thereafter. For a 25-year-old quadraplegic, that would amount to lifetime medical costs of $1.3 million; for a paraplegic, $427,700.

So common are spinal cord injuries among gunshot victims today that some health care providers suspect gunmen are deliberately aiming for the neck. "It's as if the gunmen are saying, 'We don't want to kill you; we just want to paralyze you,' " says Glick of the University of Medicine and Dentistry of New Jersey. "We want to keep you alive so you will always remember what happened to you." In Los Angeles, at least half of all spinal cord injuries are caused by gunshots. Since most insurance plans have lifetime benefit caps, even those patients with private health insurance eventually end up on Medicaid. Roughly 75 percent of all gunshot victims are under 30, as are half of all spinal cord victims. That means better survival rates, of course--and many costly years ahead.

At the Kessler Institute for Rehabilitation in West Orange, N.J., whose stellar reputation for treating head- and spinal-cord-injured victims has attracted celebrities like dancer Ben Vereen and actor Christopher Reeve, gunshot survivor Talmadge Conover improved steadily under a rehabilitation program that costs $1,000 a day. But once the 18-year-old paraplegic returned to his drab third-floor apartment in a fading section of Newark, N.J., with three bullets still in his abdomen, he found it harder to keep doing the pull-ups that flipped his skinny body from side to side. The result: bedsores so infected they started eating away at his bone. Now, Conover is recovering from a successful skin-graft operation, studying for a high school equivalency degree and working the phones from a $30,000 Clinitron bed, a sort of heated hammock of delicate silicone balls. He says he has stopped dealing cocaine. Estimated cost of his treatment: more than $134,000.

Carrying a nine. That Conover was shot with a 9-millimeter semiautomatic weapon would come as no surprise to anyone who has spent time in an urban trauma center. Introduced in the early 1980s to revive a sagging gun industry, "nines" are now the weapon of choice on city streets. They are cheap and concealable, and, with extended magazines, they allow the shooter to fire up to 36 rounds without reloading. "You carry [a nine] to get a rep," explains Matos, "to get respect."

The Treasury Department's Bureau of Alcohol, Tobacco and Firearms lists two brands of 9 millimeters--the $410 Ruger P89 and the $609 Glock 17--among the top 10 guns found at crime scenes. There are now more than

3 million 9 millimeters on America's streets, and while many of those are arming law enforcement officers, the number of 9 millimeters used by criminals has nearly doubled since 1987. In Philadelphia in 1987, 9 millimeters sent 57 victims to local trauma hospitals; by 1993, the number of victims hospitalized by 9 millimeters had soared to 351.

Vernon Parker, a 31-year-old Brooklyn man, still carries nine bullets in his right thigh from the 17 rounds of an Intratec TEC-9 semiautomatic fired into him outside a housing project in the Bedford-Stuyvesant section on Oct. 19, 1993. (The manufacture of TEC-9s, along with certain magazines, was banned under the 1994 assault weapons law, but thousands made before the ban remain in circulation.) Slugs from the TEC-9 struck Parker's groin, buttocks and shoulder, necessitating three operations and two years in the hospital. The cost: well over $500,000. Today, there is little hope that Parker will walk again. "It used to be that just flashing a gun was enough," says Parker, a convicted drug dealer who speaks from experience. "But these young guys today, they'll shoot a whole crowd in broad daylight just to get one dead."

To doctors after a while, the entries on emergency-room-admissions forms start to look the same: *GSW, BL, M, 1976, MA*--gunshot wound, black, male, 20 years old, medical assistance. Only the faces change. "There is a lot of frustration and angst about these injuries," says Stephen Hargarten, an emergency room physician at the Medical College of Wisconsin in Milwaukee. It is no longer enough, he says, for emergency room doctors to simply treat gunshot victims and release them. "Doctors must leave the bedside," he says, "and go to the legislatures."

Solutions? And so they are. Physicians are lobbying for restrictions on U.S. handguns as strict as those for imports. They want childproof guns, a heavier tax on ammunition and other reforms.

In their more discouraging moments, however, doctors admit the prognosis is poor. Nestor Cantor, after all, says he knows seven people who have been shot, six of them killed. Eddie Matos counts at least five. Talmadge Conover says he knows more than a dozen victims of handgun violence, three of them dead. He has had days when he wanted to join them. But in a country where there is one handgun for every other household, even those relegated to wheelchairs show no inclination to disarm. The phenomenon, says Cantor, "is just too big. It's out of control."

BY SUSAN HEADDEN

Read about gun-critics' recent gains in court, a *U.S.News Online* special

THE LINE ON SEMIAUTOMATICS

SPEED AND POWER: Most gunshot injuries are caused by small- and

medium-caliber revolvers, but emergency room specialists point to an alarming increase in multiple wounds caused by high-powered semiautomatic pistols.

POPULARITY: Semiautomatics are popular with the young. In one survey of inmates in four states, 55 percent of juveniles admitted to carrying a semiautomatic pistol.

FIREARMS IN CIRCULATION: 216 million

HANDGUNS IN CIRCULATION: 72 million

9-MM SEMIAUTOMATICS IN CIRCULATION: 3 million

PREVENTION: Emergency room doctors are urging policy makers to focus on gun design. There can be safer guns, they argue, just as there are safer cars.

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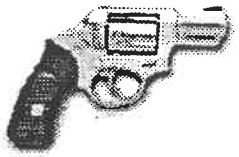
the 37-year-old pediatric neurosurgeon knows that training was naive.

Children younger than 15-years-old are 12 times more likely to die from guns than their counterparts in 25 other industrialized nations, according to the Centers for Disease Control and Prevention

"We don't have any hunting here other than people," said Levy, who works in the emergency room at the Children's Hospital of Los Angeles. "What we're seeing is gang-related murders."

Levy and his colleagues in emergency rooms around the country see more gang-related shootings than they can count, sometimes patching up the same kids over and over. Even if some statistics say fewer young people are dying from gun wounds, these doctors are running faster than ever into emergency rooms, assessing CAT scans and sometimes diagnosing who will live and who will die in split seconds.



.38 Special Ruger

About every other day, Levy treats young people shot in gang violence. The hospital only keeps track of the victims who live, and Levy has studied the numbers. In eight years, he tracked 780 patients who had gun shot wounds to the brain and no other injuries. 105 of the injured were between 6 months and 17-years-old, and 72% of those patients were victims of gang-related shooting.

"It's not an inner-city problem, it's a problem of availability to guns and society's perception of guns and how to resolve conflicts."
—Dr. John Ragheb

"You just get used to it," said Levy, "The unfortunate thing is the number of patients we've seen and taken care of is starting to outpace the military series [of gunshot wounds from combat]."

War Metaphors Describe ER Life

Like Levy, emergency room doctors and nurses across the country use military metaphors and long sighs to describe their days stitching gang members and their victims.

"I take care of kids who have brain and spinal cord injuries, and I see a lot of kids who don't survive," said Ragheb, a pediatric neurosurgeon in the emergency room of Miami's Ryder Trauma Center at Jackson Memorial Hospital, where doctors treat more than 800 gunshot wounds a year. "That's sad, but what's sadder is the kids who do survive and who can't walk or talk. They're 6 or 8-years-old and they'll never be normal."

Tracy McCaffrey, policy director for Physicians for Social Responsibility, a doctors' activist group based in Washington D.C., said that the physicians can no longer afford the luxury of just working on patients. Now, she said, many have started programs to combat gangs.

"For doctors dealing with gun wounds, [the ER] was like a MASH unit, with doctors patching people up and waiting for the next one to come in," McCaffrey said,

"And they felt their hands were tied."

From Nurse to Activist

Ragheb's colleague Mimi Sutherland, the neurological coordinator at Ryder and an adjunct instructor in neurosurgery at the University of Miami, is pioneering a get-tough education program for kids in gangs.

A nurse and a protégé of former Surgeon General C. Everett Koop, Sutherland is forcing teens to confront the consequences of gun violence.

Sometimes, Sutherland brings wheelchair-bound children into classrooms. The disabled young people tell their peers about all of the things they can't do, and what their life is like. Some teens are swayed by this, but many more are callous, Sutherland said.

Colt .45 automatic

"Many of the teenagers don't really care about the kids being injured or their families," she said. "We've had kids ask us, 'how high up do I have to shoot somebody to get their arms?' so they can paralyze them."

Still, Sutherland perseveres, often making her point with intimidating medical equipment.

"I take the largest size of all the surgical instruments from the trauma center and tell the kids that in the first 15 minutes, they can't have any pain medication," Sutherland said. She is also working with local law enforcement to encourage gun buy-back programs in inner city neighborhoods.

Younger Kids Hold Key

The trick to stopping the flow of violence, Sutherland and other medical professionals said, is to target children early, when they are still in grade school and before they have joined gangs or become inured to their peers' premature death.

Once children enter middle school, they are too far gone, many experts said.

In the Bronx, medical students at Albert Einstein Hospital teach conflict resolution and communication techniques to fourth and fifth grade public school students.

Andy Sikora, an MD/Ph.d student at Einstein, started the program when a clinical rotation in Riker's Island prison exposed him to young men riddled with bullet holes.

"They were perpetrators but also victims ... every one I came in contact with had bullet wounds," said Sikora, who grew up in Illinois, worlds away from New York's

tough streets. "They had no sense of any sort of future. When I asked them why they had no plans, their answer was 'very few of us live past 21.'"

Most urban trauma centers average two gunshot wounds to the head each week.

One Houston hospital admitted 90 gunshot wounds to the head and neck in 10 months in 1991.

In Washington D.C., gunshot wound admissions tripled in one year to more than 33 per month.

Prior to the 1960s, the largest group of gunshot wound victims was men over the age of 75, usually the result of suicide. In recent years, males 15 to 25 have become most severely affected.

In Washington, D.C., in 1989, 45 percent of patients admitted with bullet wounds had multiple entrance wounds, in 1984, 23 percent had multiple wounds.

California has one of the highest overall homicide rates in the country, nearly 70 percent of which are gun-related. In 1991 alone, there were more than 5,000 deaths from firearms.

From 1989 to 1990, 2,771 victims of gunshot wounds were admitted to the major trauma centers of Los Angeles. Of this number, 188 patients had wounds to the head. Of these, 59 died.

Approximately 600 homicide victims in Los Angeles died before reaching the hospital that year.

Homicides of urban children in Cleveland increased sevenfold from 1958 until 1982. Handguns accounted for approximately three-quarters of these deaths when the type of gun used was known.

Harlem doctors reported a 300 percent increase in gunshot wounds in 1987 as a result of the crack epidemic.

In Detroit, the mortality rates of urban dwellers under 19 increased 50 percent from 1980 to 1988 (to more than 70 deaths per 100,000 people).

From Gunshot Wounds to the Head **By Mark D. Krieger, MD; Michael L. Levy, MD; Michael L.J. Apuzzo, MD**

THE FINANCIAL IMPACT OF TREATING VICTIMS OF VIOLENCE IN THE EMERGENCY DEPARTMENT

Carl R. Boyd, Elaine I. Frantz, Don R. Lewis, Steven R. Talbert, Memorial Medical Center, Inc., Savannah, Georgia.

Objectives.

The financial impact of treating victims of violence is significant for hospitals. Although previous studies have reported the financial impact of violence for those patients admitted to the hospital, a far greater number of victims of violence are treated in the emergency department (ED) and released. The purpose of this study was to determine the costs of care and payments received for victims of violence treated in the ED and released.

Methods.

A retrospective, descriptive study of the clinical and financial data of all victims of violent trauma treated in the ED of a Level I trauma center in an urban/rural setting and released was conducted from January 1988 through December 1992. ICD-9 codes were used to identify victims of gunshot wounds (GSW), stab wounds (ST), and assault (AST). Variables studied included age, race, sex, mechanism of injury, payor class, total charges, and total collections. Hospital financial records were reviewed for the latter three variables. Physician charges were excluded. Collectibility for each payor class group for the five-year period was based on actual payments received in 1992.

Results.

During the study period, 6,367 patients were treated for violent trauma in the ED; 1,529 patients were admitted for violent injuries. Total charges for those treated and released were $2,973,658; total amount collected was $865,209 (29%). Mechanisms of injury were: GSW, 710 (11%); ST, 821 (13%); and AST, 4,836 (76%). Sixty-six percent were black and 66% were male (mean age 28 years). Twenty-five percent had commercial insurance; 15% had Medicaid; and 3% had Medicare. Therefore, 43% of patients had some form of third-party payor; 57% did not. There were no significant differences in collectibility based on mechanism of injury.

Conclusions.

The number of victims of violence treated in the ED and released was four times greater than that for those admitted. Seventy percent of charges were not recovered. The financial profile of victims of violence treated in the ED has a significant impact on hospitals treating these patients.

BY THE ASSOCIATED PRESS

Most victims of nonfatal shootings in crimes are black

WASHINGTON, 04/11/96, Associated Press - A study of nonfatal shootings resulting from crimes shows that, as with murders, most victims are black and many are teen-agers.

The Justice Department study using data from the Centers for Disease Control and Prevention also found that 58% of firearm injuries resulted from assaults. Crimes account for fewer than half of firearm deaths.

The CDC data on gun-related injuries came from 91 hospital emergency rooms around the country in the year beginning June 1, 1992. While the FBI and others track murders committed nationwide, no national registry exists for nonfatal shootings related to crime. The Justice Department's Bureau of Justice Statistics prepared the report.

It found that hospitals treated 99,000 nonfatal wounds in the one-year period, of which 58% resulted from assaults. One shooting in five was accidental, and 5% resulted from suicide attempts. The cause was unknown in 16% of cases.

The Justice Department says 47% of the 37,776 firearm deaths in 1992 resulted from homicide or legal use of firearms such as self-defense or police activity. Of the rest, 48% were suicides and 4% accidental shootings.

An FBI survey of murders that year found that 53% of the victims were black, and 38% were 15-24 years old.

Of those suffering gunshot wounds....

59% were black

19% white

14% Hispanic

About half were aged 15-24

with 22% in the 15-19 age bracket.

"One of the saving graces is that a lot of kids aren't great shots," said Susan Glick of the Violence Policy Center on the high percentage of gun crimes committed by young assailants that result in nonfatal wounds. "That will change with improved technology."

The report cited a 1995 study estimating that costs per survivor of a gunshot wound, in terms of medical care, lost productivity and reduced quality of life, averaged $260,000. Many young victims of gun-related crimes have no health insurance.

The report also found:

12% of crime-related gunshot injuries came from drive-by shootings.

1,400 police officers were injured and 67 killed in firearms assaults in 1993.

About 3% of victims of serious violent crimes from 1987 through 1992 were shot, according to the Justice Department's National Crime Victimization Survey.

Roughly 60% of assailants were strangers, 25% acquaintances and 6% relatives or intimates.

MAJOR CRIME
A HISTORIC VIEW

YEAR	HOMICIDE	RAPE	ROBBERY	AGGRAVATED ASSAULT	BURGLARY	MOTOR VEHICLE THEFT	LARCENY	VIOLENT CRIMES	PROPERTY CRIMES	PART ONE OFFENSES	% CHANGE
1970	65	94	921	596	6,558	2,433	9,408	1,676	18,399	20,075	
1971	72	131	1,266	786	6,191	2,697	8,769	2,275	17,657	19,932	-0.71%
1972	88	164	1,453	812	5,152	2,184	7,251	2,517	14,587	17,104	-14.19%
1973	71	149	1,126	786	4,298	2,009	6,843	2,132	13,150	15,282	-10.65%
1974	64	153	1,222	835	5,449	1,344	8,164	2,274	14,957	17,231	12.75%
1975	68	125	1,375	859	5,699	1,538	10,555	2,427	17,792	20,219	17.34%
1976	50	123	873	841	4,583	1,274	10,469	1,887	16,326	18,213	-9.92%
1977	64	141	861	981	4,719	1,070	10,178	2,047	15,967	18,014	-1.09%
1978	52	126	807	851	4,447	1,221	9,439	1,836	15,107	16,943	-5.95%
1979	50	161	985	1,036	5,192	1,218	10,184	2,232	16,594	18,826	11.11%
1980	58	157	1,130	1,086	6,601	1,261	11,231	2,431	19,093	21,524	14.33%
1981	48	195	1,384	1,061	7,412	1,037	13,649	2,668	22,098	24,766	15.06%
1982	72	171	1,395	1,139	6,824	996	11,870	2,777	19,690	22,467	-9.28%
1983	62	194	1,469	1,193	7,487	901	11,754	2,938	20,142	23,080	2.73%
1984	78	205	1,278	1,198	5,465	903	10,149	2,759	16,517	19,276	-16.48%
1985	92	213	1,061	1,261	4,307	1,020	9,622	2,647	14,949	17,596	-8.72%
1986	82	207	1,017	1,280	4,481	1,139	10,051	2,586	15,671	18,257	3.76%
1987	80	182	1,083	1,271	4,143	1,838	9,969	2,616	15,950	18,566	1.69%
1988	99	202	982	1,301	4,773	2,203	10,554	2,584	17,530	20,114	8.34%
1989	98	180	1,085	1,565	4,656	2,020	11,763	2,928	18,439	21,367	6.23%
1990	113	180	1,281	1,655	4,396	2,417	13,001	3,229	19,814	23,043	7.84%
1991	116	150	1,449	1,698	4,822	2,740	12,941	3,413	20,503	23,916	3.79%
1992	117	178	1,459	1,356	4,677	2,413	12,046	3,110	19,136	22,246	-6.98%
1993	112	174	1,578	1,411	5,081	2,215	11,571	3,275	18,867	22,142	-0.47%
1994	160	169	1,586	1,679	4,934	2,641	10,835	3,594	18,410	22,004	-0.62%
1995	120	171	1,491	1,718	4,260	2,376	10,848	3,500	17,484	20,984	-4.64%
1996	112	143	1,545	1,583	4,022	2,026	10,338	3,383	16,386	19,771	-5.76%
TOTAL	**2,263**	**4,438**	**33,202**	**31,838**	**140,629**	**47,136**	**283,452**	**71,741**	**471,217**	**542,958**	
AVERAGE PER YEAR	**84**	**164**	**1,230**	**1,179**	**5,208**	**1,746**	**10,498**	**2,657**	**17,452**	**20,110**	

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Murder/Nonnegligent Manslaughter

The charts below illustrate the number and percent distribution by type of weapon used. and situation in the commission of murders in Virginia in 1992.

Type	Number	% DISTRIBUTION
Unknown gun	10	1.8
Handgun	338	60.0
Shotgun	39	6.9
Rifle	20	3.6
Knife	70	12.4
Club	26	4.6
Hands, Fist, Feet	35	6.2
Other	12	2.1
Unknown	13	2.3
Total	563	100.0

*SITUATIONS
A—Single Victim/Single Offender
B—Single Victim/Unknown Offender or Offenders
C—Single Victim/Multiple Offenders
D—Multiple Victims/Single Offender
E—Multiple Victims/Multiple Offenders
F—Multiple Victims/Unknown Offender or Offenders

Situations	Number	% DISTRIBUTION
A	306	57.0
B	145	27.0
C	66	12.3
D	8	1.5
E	5	.9
F	7	1.3
Total	537	100.0

Due to rounding, figures may not total 100%.

Murder/Nonnegligent Manslaughter

The charts below illustrate the number and percent distribution by type of weapon used, and situation in the commission of murders in Virginia in 1993.

Type	Number	% DISTRIBUTION
Unknown gun	11	2.0
Handgun	325	60.3
Shotgun	41	7.6
Rifle	17	3.2
Knife	70	13.0
Club	26	4.8
Hands, Fist, Feet	25	4.6
Other	13	2.4
Unknown	11	2.0
Total	539	100.0

*SITUATIONS
A—Single Victim/Single Offender
B—Single Victim/Unknown Offender or Offenders
C—Single Victim/Multiple Offenders
D—Multiple Victims/Single Offender
E—Multiple Victims/Multiple Offenders
F—Multiple Victims/Unknown Offender or Offenders

Situations	Number	% DISTRIBUTION
A	316	61.5
B	120	23.3
C	55	10.7
D	13	2.5
E	7	1.4
F	3	.6
Total	514	100.0

Due to rounding, figures may not total 100%.

Murder/Nonnegligent Manslaughter

The charts below illustrate the number and percent distribution by type of weapon used, and situation in the commission of murders in Virginia in 1994.

Type	Number	% Distribution
Unknown gun	13	2.3
Handgun	367	64.4
Shotgun	22	3.9
Rifle	17	3.0
Knife	68	11.9
Club	15	2.6
Hands, Fist, Feet	30	5.3
Other	24	4.2
Unknown	14	2.5
Total	570	100.0

*SITUATIONS
A–Single Victim/Single Offender
B–Single Victim/Unknown Offender or Offenders
C–Single Victim/Multiple Offenders
D–Multiple Victims/Single Offender
E–Multiple Victims/Multiple Offenders
F–Multiple Victims/Unknown Offender or Offenders

Situations	Number	% Distribution
A	286	53.9
B	156	29.4
C	64	12.1
D	16	3.0
E	2	.4
F	7	1.3
Total	531	100.0

Due to rounding, figures may not total 100%.

Murder/Nonnegligent Manslaughter

The charts below illustrate the number and percent distribution by type of weapon used. and situation in the commission of murders in Virginia in 1996.

Type	Number	% Distribution
Unknown gun	24	4.8
Handgun	258	52.0
Shotgun	29	5.8
Rifle	17	3.4
Knife	79	15.9
Club	17	3.4
Hands, Fist. Feet	36	7.3
Other	21	4.2
Unknown	15	3.0
Total	496	100.0

*SITUATIONS
A-Single Victim/Single Offender
B-Single Victim/Unknown Offender or Offenders
C-Single Victim/Multiple Offenders
D-Multiple Victims/Single Offender
E-Multiple Victims/Multiple Offenders
F-Multiple Victims/Unknown Offender or Offenders

Situations	Number	% Distribution
A	276	58.6
B	142	30.1
C	33	7.0
D	9	1.9
E	4	.8
F	7	1.5
Total	471	100.0

Due to rounding, figures may not total 100%.